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Cover Page Footnote

A sincere thank you to my friends and family for their positive encouragement and endless, brimming cups of coffee. Special gratitude is due to Sarah DePanfilis, Elysa Goldberg, Carla Pasquale, Professor Andrew Sims, and of course, my parents, Alana, Melissa, and Keith. Lastly, thank you to my inspiring mentor, attorney Catherine S. Nietzel.

IT'S BEEN A PRIVILEGE: ADVISING PATIENTS OF THE *TARASOFF* DUTY AND ITS LEGAL CONSEQUENCES FOR THE FEDERAL PSYCHOTHERAPIST-PATIENT PRIVILEGE

*Elisia Klinka**

State laws modeled on Tarasoff v. Regents of the University of California *require psychotherapists to warn potential victims or law enforcement when treating dangerous patients who make serious threats of harm to another person. In practice, many psychotherapists advise their patients who make such threats about their duty under these* Tarasoff*-model laws. Although they are not required to make these advisories by law, psychotherapists generally assume that they also have a concomitant ethical duty to advise their patients that such threats will not be kept confidential, as their communications normally would be. This Note looks at how these advisories affect the status of privilege for subsequent threatening statements relayed to a psychotherapist. It explores the opposing views in the federal circuit courts regarding whether such an advisory precludes the existence of privilege for subsequent statements, or whether the advisory operates as a waiver to the privilege. This Note argues that threats communicated to a psychotherapist after an advisory about a psychotherapist's* Tarasoff *duty cannot be considered privileged if the patient intended for the threat to be passed on to a third party. Psychotherapists must now be aware of the possible legal consequences regarding the patients' diminished expectation of confidentiality and lack of privilege following such advisories. In order to act in their patients' best interest, psychotherapists should educate themselves about the scope of a* Tarasoff *duty in their applicable states and should consider alternative intervention techniques that could reduce dangerous patients' risk of harm. Psychotherapists should continue to follow professional ethical guidelines about advising patients of the limits of confidentiality, but implement techniques that evidence the patients' true intent about confidentiality, in order to bolster the patients' possible privilege claims later on and minimize harm to the treatment relationship.*

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* J.D. Candidate, 2010, Fordham University School of Law. A sincere thank you to my friends and family for their positive encouragement and endless, brimming cups of coffee. Special gratitude is due to Sarah DePanfilis, Elysa Goldberg, Carla Pasquale, Professor Andrew Sims, and, of course, my parents, Alana, Melissa, and Keith. Lastly, thank you to my inspiring mentor, attorney Catherine S. Nietzel.

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INTRODUCTION

> If you reveal your secrets to the wind you should not blame the wind for revealing them to the trees.[1]

Heed this advice: Perhaps you should not assume that everything you tell your therapist will be kept in confidence. Laws dictate otherwise. In fact, your therapist may even tell you this directly.[2] Most psychotherapists

1. KAHLIL GIBRAN, SAND AND FOAM: A BOOK OF APHORISMS 69 (Alfred A. Knopf, Inc. 1995) (1926).
2. *See infra* notes 213–15 and accompanying text.

would prefer to be honest with you about possible limits of privacy, rather than operate behind a veil of absolute confidence. Many patients would even say that it is their right to know what will not be kept confidential.[3]

In *Tarasoff v. Regents of the University of California*,[4] the Supreme Court of California articulated what is now known as a *Tarasoff* duty. "The general formulation is that a mental health worker is obligated promptly to notify either the potential victim or the police when a patient makes an explicit threat of serious physical harm against a readily identifiable third party . . . ."[5]

As soon as *Tarasoff* was decided, many feared that the legally required breach of confidentiality would create a chilling effect.[6] Those patients already in therapy would feel betrayed by their therapist and those not in therapy would be dissuaded from ever beginning.[7] Many thought it would force therapists into a difficult role.

Rather than stay an anomalous opinion, the *Tarasoff* duty has expanded into many different forms and requirements in most states.[8] The predicted adverse effects upon the treatment relationship did not materialize, at least in any reviewable or proven way.[9] Many questions remain. Are *Tarasoff* warnings commonly issued by psychotherapists? How aware is the public about the psychotherapist's duty to warn? And more specifically, are patients aware of these laws that limit presumed confidentiality?

One way that psychotherapists have been able to maintain trust with their patients, while also abiding by their states' *Tarasoff*-model law, is by advising patients of their legally required *Tarasoff* warning.[10] However, there is new concern regarding the consequences of such an advisory to the patient.[11] In 1996, the U.S. Supreme Court established a federal psychotherapist-patient privilege protecting a patient's confidential communication with a psychotherapist in the course of treatment or diagnosis.[12] The privilege protects a patient's confidential communication from compelled disclosure, which also means that a psychotherapist cannot testify about the patient's communication in a court proceeding, unless the patient waives the privilege.[13] This Note looks at the tenuous nature of a psychotherapist's professional responsibility to inform a patient about the

3. *See infra* note 203 and accompanying text.

4. 551 P.2d 334 (Cal. 1976).

5. Paul B. Herbert & Kathryn A. Young, Tarasoff *at Twenty-Five*, 30 J. AM. ACAD. PSYCHIATRY L. 275, 277 (2002).

6. *See infra* notes 236–39 and accompanying text (discussing the "deterrence hypothesis").

7. *See infra* notes 236–39.

8. *See infra* Part I.B.2.

9. *See infra* notes 237–53 and accompanying text.

10. *See infra* Part I.B.3.

11. *See infra* text accompanying note 515.

12. *See* Jaffee v. Redmond, 518 U.S. 1 (1996).

13. *Id.* at 15 & n.14; *see* FED. R. EVID. 1101(c) ("The rule with respect to privileges applies to all stages of all actions, cases, and proceedings."); CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE § 5.1, at 330 (1995).

limits of confidentiality when a *Tarasoff* warning becomes legally necessary. Essentially, the psychotherapist's advisory to the patient destroys the patient's expectation of confidentiality regarding future threats of violence and departs from the tenets of a testimonial privilege.

To illustrate, *Mr. A* is a police officer who was injured on the job and has been receiving workers' compensation benefits.[14] *Mr. A* does not trust that his employer is going to keep paying what he deserves. In fact, *Mr. A* feels the administration is looking for ways to stop paying him, and he consistently feels cheated and harassed. *Mr. A* shares these feelings of anger with his longtime psychotherapist and even reveals that he has been having nightmares where he wants to kill those responsible for cutting off his money source. In this hypothetical, assume it is typical for this therapist to remind a patient that, if he makes any serious threats of harm to others, she will have a duty to report it to the police or advise his former employers that they could be in danger.

Finally, one day *Mr. A*'s rage escalates and he tells his psychotherapist that he cannot take the harassment anymore and threatens "violent retribution" if he does not receive his workers' compensation payments. Again, the psychotherapist advises *Mr. A* that he will have to report this threat to the claims managers; this time, the therapist does it. Despite the *Tarasoff* warning (and importantly, despite the patient's awareness of the *Tarasoff* warning that would be made), the patient continued to divulge plans of violence against specific people in charge of his benefits. In fact, *Mr. A* is glad that his therapist will be disclosing his threats because they will take his demands seriously now. Subsequently, *Mr. A* is arrested for extortion, and his psychotherapist is called to testify against him.

As stated above, the patient's knowledge that certain threatening statements made to a psychotherapist will not be held in confidence directly affects the status of privilege for similar subsequent statements. This Note addresses a split among the U.S. courts of appeals regarding whether the patient's lack of an expectation of confidentiality precludes the existence of privilege for future statements, or whether the advice to the patient was informative enough to operate as a waiver of privilege. Part I of this Note provides context for this discussion by explaining the foundations and scope of privilege in general and the federal psychotherapist-patient privilege established by the U.S. Supreme Court in *Jaffee v. Redmond*.[15] This Part also describes the *Tarasoff* duty and how psychotherapists handle this duty in practice.

Part II reviews the circuit split regarding whether a patient's threat after a *Tarasoff*-predicated advisory is privileged. The U.S. Court of Appeals for the Tenth Circuit decided that such a communication is not privileged when a *Tarasoff* warning is the only way to avert harm from a serious threat,

14. This hypothetical is based on the facts of *United States v. Auster*, 517 F.3d 312, 313 (5th Cir.), *cert. denied*, 129 S. Ct. 75 (2008). This case is discussed in greater detail below. *See infra* Part II.C.2.

15. *See Jaffee*, 518 U.S. at 15.

regardless of whether the patient knew that there would be this breach of confidentiality.[16] The U.S. Courts of Appeals for the Sixth and Ninth Circuits have, instead, held that privilege is maintained despite the *Tarasoff* warning and regardless of the patient's knowledge that the communication would not be kept confidential.[17] In contrast, the U.S. Court of Appeals for the Fifth Circuit held that privilege does not exist if the patient has already received an advisory about the psychotherapist's *Tarasoff* duty before making the threat.[18]

Finally, Part III argues that threats communicated to a psychotherapist after the patient is given an advisory about the psychotherapist's *Tarasoff* duty are not privileged as a matter of law when the patient never intended for them to be confidential. Although this Note endorses the legal analysis adopted by the Fifth Circuit, it also seeks to offer ways that psychotherapists can continue to implement effective informed consent, possibly preserve a patient's privilege claim later on, and minimize harm to the psychotherapist-patient treatment relationship.

I. FEDERAL PSYCHOTHERAPIST-PATIENT PRIVILEGE AND PSYCHOTHERAPISTS' *TARASOFF* DUTY

This Part provides background for discussion of the circuit split. Part I.A describes the development of a federal psychotherapist-patient testimonial privilege. First, it explores the foundations of evidentiary privilege in general, including who holds privilege, what communication is protected, and the ways to waive or lose privilege. Next is a review of the establishment and scope of a federal psychotherapist-patient privilege in common law. Part I.B describes the nature of a *Tarasoff* warning and the adoption of laws modeled after *Tarasoff* in most states. Part I.B also discusses how psychotherapists have treated the *Tarasoff* duty and how many have decided to inform their patients about this duty. Lastly, this Part explores whether the suspected detrimental effects from the breach of confidentiality that inevitably flow from a *Tarasoff* warning have ever been substantiated in empirical evidence.

A. *Development of a Federal Psychotherapist-Patient Privilege*

1. Privilege in General

Courts are reluctant to establish evidentiary privileges.[19] This is because, "[w]hile other evidentiary rules aim to improve the reliability of evidence,

16. *See* United States v. Glass, 133 F.3d 1356 (10th Cir. 1998).

17. *See* United States v. Hayes, 227 F.3d 578 (6th Cir. 2000); *see also* United States v. Chase, 340 F.3d 978 (9th Cir. 2003) (en banc).

18. *Auster*, 517 F.3d at 313.

19. Deirdre M. Smith, *An Uncertain Privilege: Implied Waiver and the Evisceration of the Psychotherapist-Patient Privilege in the Federal Courts*, 58 DEPAUL L. REV. 79, 90 (2008).

leading to enhanced truth-seeking by fact finders and more efficient trials, privileges provide benefits outside adjudication, such as the preservation or protection of certain interpersonal relationships."[20]

Generally, courts recognize four fundamental conditions as necessary for the establishment of a privilege.[21] First, the "communications must originate in a confidence that they will not be disclosed."[22] Second, confidentiality "must be essential to the full and satisfactory maintenance of the relation between the parties."[23] Third, the relationship seeking privilege must be one in which "the opinion of the community ought to be sedulously fostered."[24] Fourth, the injury that would result to the relation by the disclosure of the confidential communications must be greater than the benefit derived from confidentiality.[25] These four conditions are the cornerstones of a privilege because they "serve as the foundation of policy for determining all . . . privileges, whether claimed or established" so that "[o]nly if these four conditions are present should a privilege be recognized."[26]

The requirement of confidentiality is a fixture in contemporary privilege doctrine, as demonstrated by the first of the four conditions.[27] If the communication does not "'originate in a confidence,'" then "there is no privilege."[28] At the very time of communication, the privilege holder must have intended to keep the communication secret from everybody outside the circle of confidence.[29] For example, there is no privilege when the communication is made in the presence of third parties or when the patient intends for the information to be imparted to others.[30] Therefore, the

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20. *Id.*

21. 8 JOHN H. WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2285, at 527 (1961). For a discussion of the reason courts traditionally prefer to strictly construe privileges in line with Dean John Henry Wigmore's instrumentalist approach to evidence, see Smith, *supra* note 19, at 91–92.

22. 8 WIGMORE, *supra* note 21, § 2285, at 527.

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.* § 2285, at 527–28; *see* LeRoy G. Schultz, *Confidentiality, Privilege, and Child Abuse Reporting*, 2 ISSUES CHILD ABUSE ACCUSATIONS 210, 211 (1990) ("Unless these four criteria are fulfilled, confidentiality cannot be expected, and failure to establish confidentiality negates the possibility of privileged communication.").

27. *See* EDWARD J. IMWINKELRIED, THE NEW WIGMORE: A TREATISE ON EVIDENCE: EVIDENTIARY PRIVILEGES § 6.8, at 666–71 (Richard D. Friedman ed., 2002).

28. *Id.* § 6.8, at 671 (quoting 8 WIGMORE, *supra* note 21, § 2285, at 527).

29. *Id.* § 6.8, at 668–69; *see* SAMUEL KNAPP & LEON VANDECREEK, PRIVILEGED COMMUNICATIONS IN THE MENTAL HEALTH PROFESSIONS 66 (1987) ("[C]ommunications should be confidential only if they are intended as such.").

30. *See* IMWINKELRIED, *supra* note 27, § 6.8, at 670–71; *see also* United States v. Auster, 517 F.3d 312, 317 n.16 (5th Cir.) ("'It is vital to a claim of privilege that the communication have been made and maintained in confidence. Thus courts have refused to apply the privilege to information that the client intends his attorney to impart to others, or to communications made in the presence of third parties.'" (alteration in original) (quoting United States v. Pipkins, 528 F.2d 559, 563 (5th Cir. 1976))), *cert. denied*, 129 S. Ct. 75 (2008).

confidentiality requirement of privilege must attach at the time of the communication.[31] Furthermore, there is no purpose "to confer privilege protection when the person himself or herself had no such expectation . . . When the person lacked that expectation of confidentiality, the social interest in making relevant evidence available to litigants becomes paramount."[32] Enforcement of the confidentiality requirement helps to ensure that courts do not apply privilege in such an overly inclusive way so as to suppress testimony about communications that would have occurred regardless of the existence of privilege.[33]

A person claiming the privilege has the burden of proving each element of the prima facie case for privilege, including the confidentiality element.[34] Furthermore, the "burden applies to each separate statement or item as to which a claim of privilege is made."[35]

2. Waiver in General

The privilege holder must establish the absence of waiver, the same way he must establish existence of privilege.[36] Generally, when a privilege holder voluntarily discloses his confidential communication to others, he waives its privileged status.[37] However, "[i]t is equally important to distinguish the confidentiality requirement from . . . waiver problems . . . ."[38] The confidentiality element of privilege requires that at the time of the communication, "the holder must have an intent to maintain confidentiality in the future."[39] A waiver can arise when the holder originally entertained the required intent at the time of the communication, but "later engage[s] in conduct manifesting an intent to surrender that confidentiality" (e.g., where the holder later discloses the communication to a third party).[40] Thus, there is a meaningful difference between no

31. IMWINKELRIED, *supra* note 27, § 6.8, at 671.

32. *Id.* § 6.8, at 669–70.

33. *Id.* § 6.8, at 668 n.1; *cf.* Melanie B. Leslie, *The Costs of Confidentiality and the Purpose of Privilege*, 2000 WIS. L. REV. 31, 47 (discussing privilege in the context of attorney-client relationships and affirming that case law continues to enforce the confidentiality requirement).

34. *See* IMWINKELRIED, *supra* note 27, § 6.3.1, at 525, § 6.8, at 671; *see also* James v. Harris County, 237 F.R.D. 606, 609 (S.D. Tex. 2006) (citations omitted) (asserting party must establish both the existence of the privilege and the absence of waiver); Speaker v. County of San Bernardino, 82 F. Supp. 2d 1105, 1108 (C.D. Cal. 2000) ("[T]he burden of proof for the psychotherapist/patient privilege is on the party seeking to establish that the privilege applies.").

35. United States v. Whitney, No. 05-40005-FDS, 2006 WL 2927531, at *3 (D. Mass. Aug. 11, 2006).

36. *See James*, 237 F.R.D. at 609; *see also* 2 CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, FEDERAL EVIDENCE § 5.33, at 668 (3d ed. 2007).

37. *See* KNAPP & VANDECREEK, *supra* note 29 at 64; 2 MUELLER & KIRKPATRICK, *supra* note 36, § 5.33, at 665; Smith, *supra* note 19, at 103–04.

38. IMWINKELRIED, *supra* note 27, § 6.8, at 671.

39. *Id.*

40. *Id.*

privilege from the start and waiver of privilege.[41] In the waiver analysis, "although the privilege initially attached at the time of communication, the holder's later conduct destroys the privilege."[42] For example, in the context of attorney-client privilege, "if the client intends that what he tells [his] lawyer . . . should be immediately disclosed, no privilege attaches because such communications fail the confidentiality requirement."[43] Also, once privilege is waived, the former holder generally cannot reclaim the privilege.[44] The privilege holder alone has the right to waive it.[45]

Of course, the holder of an evidentiary privilege can waive privilege even without the awareness he had held it.[46] This is because voluntary disclosure waives privilege

> even if the client speaks without intentionally or purposefully relinquishing his privilege claim, so long as he intentionally and purposefully reveals the substance of a confidential communication. In other words, waiver need not be 'knowing' in the sense of awareness by the client that disclosure results in loss of the privilege, so long as the client 'knows' that he is disclosing.[47]

This logic stems from the confidentiality requirement of the privilege itself.[48] If there is intent that communication is disclosed to a third party, then there is no confidentiality.[49] Further, "[t]here is always also the objective consideration that when his conduct touches a certain point of disclosure, fairness requires that his privilege shall cease whether he intended that result or not."[50]

The concept of selective waiver, in which a client makes limited disclosure of the confidential communication without waiving privilege, is generally not favored in evidence.[51] There are several concerns raised when selective disclosure is asserted: what the disclosure might leave to protect, whether "confidentiality is no longer *intended* for the communication," whether "the disclosure may have publicized the

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41. There is also a distinguishing line between an "exception" to privilege that "generally limits the privilege based upon the content of the communication [so that] the privilege is regarded as never attaching to the communication," and "the concept of waiver [which] is more appropriately considered *after* the fact of the confidential communication, once the privilege . . . [has] attached." Smith, *supra* note 19, at 104.

42. IMWINKELRIED, *supra* note 27, § 6.8, at 671; *see* Smith, *supra* note 19, at 103 (recognizing that waiver requires an affirmative act on the part of the privilege holder).

43. *See* 2 MUELLER & KIRKPATRICK, *supra* note 36, § 5.33, at 675–76.

44. *See* IMWINKELRIED, *supra* note 27, § 6.8, at 671.

45. 2 MUELLER & KIRKPATRICK, *supra* note 36, § 5.33, at 666.

46. *Developments in the Law—Privileged Communications*, 98 HARV. L. REV. 1450, 1629 n.1 (1985).

47. *See* 2 MUELLER & KIRKPATRICK, *supra* note 36, § 5.33, at 668–69 (citations omitted).

48. *See supra* notes 27–33 and accompanying text.

49. *See* 8 WIGMORE, *supra* note 21, § 2327, at 636.

50. *See id.*

51. *See* 2 MUELLER & KIRKPATRICK, *supra* note 36, § 5.33, at 671–72. *But see Developments in the Law—Privileged Communications*, *supra* note 46, at 1643–48 (recommending an intermediate approach where full waiver of privilege would not necessarily result from selective disclosure of confidential information).

privileged material to such an extent that exclusion of the information would undermine public confidence in judicial resolution of disputes," and whether "the disclosure without waiver might extend the privilege unjustifiably."[52] Selective waiver is usually, perhaps exclusively, discussed in the context of attorney-client privilege and disclosures by businesses to governmental bodies during investigations or proceedings.[53] At the same time, proponents of the selective waiver doctrine argue that allowing privilege holders to share their private communications with outsiders would not necessarily invite manipulation.[54] In fact, Federal Rule of Evidence 502, which took effect on September 19, 2008, addresses limitations of waiver in the context of attorney-client privilege: "[a] federal court may order that the privilege or protection is not waived by disclosure connected with the litigation pending before the court—in which event the disclosure is also not a waiver in any other federal or state proceeding."[55]

3. *Jaffee v. Redmond*: Construction of a Federal Psychotherapist-Patient Privilege

In 1972, the Judicial Conference Advisory Committee suggested the recognition of nine different federal privileges, including Federal Rule of Evidence 504 proposing the psychotherapist-patient privilege.[56] Proposed Rule 504(b) stated, "A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purposes of diagnosis or treatment of his mental or emotional condition . . . ."[57] Section (a)(3) of this Rule further defined a communication as "confidential" if it was not intended to be disclosed to

52. *Developments in the Law—Privileged Communications*, *supra* note 46, at 1645; *see* 2 MUELLER & KIRKPATRICK, *supra* note 36, § 5.33, at 672–73 ("Perhaps the best that may be said for the rule against selective disclosure is that it spares courts from addressing hard questions, as it is at least a little bit easier simply to say that disclosure waives the privilege.").

53. *See* Diversified Indus., Inc. v. Meredith, 572 F.2d 596 (8th Cir. 1977) (holding that the disclosure of privileged attorney-client communications to a government agency constitutes a "selective waiver" that does not abrogate the privilege as to other parties). *But see In re* Qwest Commc'ns Int'l Inc., 450 F.3d 1179, 1192 (10th Cir. 2006); Mitchell M. Simon, *Discreet Disclosures: Should Lawyers Who Disclose Confidential Information To Protect Third Parties Be Compelled To Testify Against Their Clients?*, 49 S. TEX. L. REV. 307, 328–29 (2007) (arguing against selective waiver in the context of whether attorneys who disclose confidential information to protect third parties can be compelled to testify). *See generally* Kenneth S. Broun & Daniel J. Capra, *Getting Control of Waiver of Privilege in the Federal Courts: A Proposal for Federal Rule of Evidence 502*, 58 S.C. L. REV. 211 (2006); Liesa L. Richter, *Corporate Salvation or Damnation? Proposed New Federal Legislation on Selective Waiver*, 76 FORDHAM L. REV. 129 (2007).

54. 2 MUELLER & KIRKPATRICK, *supra* note 36, § 5.33, at 672.

55. *See* FED. R. EVID. 502.

56. Proposed FED. R. EVID. 504, 56 F.R.D. 183, 240–41 (1972); *see* Dale Colledge et al., *What's up Doc?* Jaffee v. Redmond *and the Psychotherapeutic Privilege in Criminal Justice*, 28 J. CRIM. JUST. 1, 3 (2000).

57. Proposed FED. R. EVID. 504, 56 F.R.D. at 241.

third persons.[58] The Advisory Committee concluded that the psychotherapist-patient privilege was justified because

> the psychiatrist has a special need to maintain confidentiality. His capacity to help his patient is completely dependent upon their willingness and ability to talk freely. This makes it difficult if not impossible for him to function without being able to assure his patients of confidentiality and, indeed, privileged communication . . . [T]here is wide agreement that confidentiality is a *sine qua non* for successful psychiatric treatment.[59]

The Committee also concluded that the four bedrock conditions needed to justify the existence of a privilege, as propounded by Dean John Henry Wigmore and described in Part I.A.1 of this Note, are "amply satisfied" for a psychotherapist-patient privilege.[60] However, Proposed Rule 504(d) also suggested three exceptions to the privilege: involuntary hospitalization, litigation proceedings in which a party relies upon a mental or emotional condition as an element of his claim or defense, and examinations that are judicially ordered.[61]

In 1974, rather than adopt the specificity of Proposed Rule 504, Congress enacted Federal Rule of Evidence 501, which authorizes federal courts to create new privileges as appropriate in common law.[62] The broadly written rule declared that privilege "shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience."[63]

About two decades later, in 1996, the Supreme Court officially recognized a federal psychotherapist-patient privilege "in light of reason and experience." The Court relied on Federal Rule 501 to establish a federal psychotherapist-patient privilege in *Jaffee v. Redmond*.[64] In this landmark case, a police officer sought mental health counseling from a social worker after a traumatic incident in which she shot and killed a man.[65] The police officer was then sued in civil litigation brought by the decedent's estate alleging that she used excessive force. At issue was whether the litigant could have access to the officer's psychotherapy

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58. *Id.* It defined third persons as "other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family." *Id.*

59. Proposed FED. R. EVID. 504 advisory committee's note, 56 F.R.D. 183, 242 (1972).

60. *Id.* (citing Ralph Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 184 (1960)); *see supra* notes 21–26 and accompanying text.

61. Proposed FED. R. EVID. 504(d)(1)–(3), 56 F.R.D. 183, 241 (1972).

62. *See* FED. R. EVID. 501; *see also* Colledge et al., *supra* note 56, at 2 (noting that previous Supreme Court rulings interpret Rule 501 as "authorizing the Court to continue the evolutionary development of testimonial privileges").

63. FED. R. EVID. 501.

64. *See* Jaffee v. Redmond, 518 U.S. 1, 5–17 (1996).

65. *Id.* at 3–4.

records.[66] The Court held that "confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence."[67]

The Court noted that any privilege recognized under Rule 501 must serve important public interests.[68] Thus, "[e]ffective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears [without the risk of] embarrassment or disgrace."[69] The Court further recognized that "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."[70] The psychotherapist-patient privilege was justified based on both "reason and experience" regarding the promotion of effective mental health counseling with assured confidentiality.[71]

4. Application of the Federal Psychotherapist-Patient Privilege in Case Law

a. *Privilege Protects Patients' Confidential Communications*

The psychotherapist-patient relationship usually, and presumably, originates in confidentiality.[72] Indeed, "confidentiality is at the heart of the psychotherapist-patient relationship."[73] Communications between a psychotherapist and patient "originate with the belief that they will not be discussed outside the office."[74] Therefore, "[t]he relationship between the psychotherapist and patient implies a contract that the information will remain private . . . [since] during psychotherapy, patients reveal the darkest aspects of their personality to a psychotherapist who gains confidences through promises of trust and shared secrecy."[75] There is little disagreement with the premise that patients enter therapy with the

66. *Id.* at 5.
67. *Id.* at 15.
68. *Id.* at 11; *see* Colledge et al., *supra* note 56, at 2 (citing *Jaffee*, 518 U.S. at 11 (1996)).
69. *Jaffee*, 518 U.S. at 10.
70. *Id.*
71. *See id.*
72. *See* KNAPP & VANDECREEK, *supra* note 29, at 9.
73. 2 STEPHEN A. SALTZBURG, MICHAEL M. MARTIN & DANIEL J. CAPRA, FEDERAL RULES OF EVIDENCE MANUAL § 501.02[6], at 501-61 (9th ed. 2006) (citing 8 WIGMORE, *supra* note 21) (characterizing one of the points made in the *Jaffee* decision).
74. *See* KNAPP & VANDECREEK, *supra* note 29, at 9; *see also* THOMAS G. GUTHEIL & PAUL S. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 11 (1982) ("The essence of [psychotherapeutic] treatment rests on an assumption of inviolate confidentiality . . . ."); *infra* notes 199–202.
75. KNAPP & VANDECREEK, *supra* note 29, at 9, 141.

expectation of confidentiality.[76] Indeed, this premise finds support in several empirical studies.[77]

In *Jaffee*, the Court decided that the federal psychotherapist-patient privilege extends to confidential communications made to licensed psychiatrists, psychologists, and social workers in the course of psychotherapy.[78] The federal privilege is often broken down into three requirements: (1) the communication must be confidential, (2) the communication must be with a licensed psychotherapist, and (3) the communication must take place in the course of therapy.[79] Since the creation of this federal privilege in 1996, case law has developed to further test the scope and limits of these components. This Note focuses on the first component, which is the confidentiality requirement.

According to *Jaffee,* a patient's communication must be confidential in order for privilege to attach.[80] The confidentiality requirement means that "the communication must be made in a confidential or private setting, outside the presence of third parties and not intended to be disclosed to others."[81] Indeed, "[w]ithout an expectation of privacy on the part of the patient, there is no private interest to be protected. Also, there is no public interest in protecting such communications from disclosure in court."[82]

Since *Jaffee*, federal courts have generally held testimonial privilege cannot be invoked where the patient had no reasonable expectation that the communications would remain private.[83] Many of these cases have arisen in the context of therapy or psychological evaluations mandated by

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76. *See Developments in the Law—Privileged Communications*, *supra* note 46, at 1546.

77. *See* KNAPP & VANDECREEK, *supra* note 29, at 10 (citing Paul S. Appelbaum et al., *Confidentiality: An Empirical Test of the Utilitarian Perspective*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 109, 112–13 (1984) (survey demonstrated that patients placed high value on confidentiality and sixty-two percent felt negatively about psychotherapists disclosing information without their consent); Donald Schmid et al., *Confidentiality in Psychiatry: A Study of the Patient's View*, 34 HOSP. & COMMUNITY PSYCHIATRY 353, 354 (1983) (survey showed most patients highly valued confidentiality and believed their confidences to be well kept); Daniel W. Shuman & Myron S. Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Privilege*, 60 N.C. L. REV. 893, 925 (1982) (survey indicated ninety-six percent of patients relied on psychotherapists' ethics to provide assurance of confidentiality)).

78. Jaffee v. Redmond, 518 U.S. 1, 15 (1996).

79. *See* Melissa L. Nelken, *The Limits of Privilege: The Developing Scope of Federal Psychotherapist-Patient Privilege Law*, 20 REV. LITIG. 1, 8–9 (2000) (citing *Jaffee*, 518 U.S. at 15); *see also* Julia P. Mitrevski & John R. Chamberlain, *Psychotherapist-Patient Privilege: Applying* Jaffe v. Redmond*: Communications to a Psychotherapist Are Not Privileged If They Occur Outside the Course of Diagnosis or Treatment*, 34 J. AM. ACAD. PSYCHIATRY & L. 245, 245 (2006); *see, e.g.*, United States v. Whitney, No. 05-40005-FDS, 2006 WL 2927531, at *2–3 (D. Mass. Aug. 11, 2006) (walking through the three requirements of *Jaffee* in its privilege analysis).

80. Nelken, *supra* note 79, at 12 (citing *Jaffee*, 518 U.S. at 9).

81. *Whitney*, 2006 WL 2927531, at *2; *see supra* notes 28–32 and accompanying text.

82. Nelken, *supra* note 79, at 12; *see supra* text accompanying note 68.

83. *See* Nelken, *supra* note 79, at 12–13; *see also* Schultz, *supra* note 26, at 211 (Even in psychotherapy, "conditions could be created that negate a reasonable expectation of privacy and or confidentiality.").

employers (usually police departments).[84] For example, in *Kamper v. Gray*,[85] the U.S. District Court for the Eastern District of Missouri determined that no privilege existed where the police officer "was aware that his evaluations would be reported to his employer, [and he therefore] had no reasonable expectation of confidentiality regarding his communications [with the psychotherapist]."[86] There, the communications did not originate in a confidential setting that would predicate privilege.[87] The court further determined that whether the officer waived privilege was not an issue that needed to be addressed, since the court found that privilege had never been established.[88]

The same issue was addressed in *Barrett v. Vojtas*.[89] The court found no privilege existed because the police officer knew that a status report and recommendation regarding his return to work would be given to his employer.[90] The officer was specifically informed that the communications would not be confidential.[91] The court held that "communications that are intended to be disclosed to third parties are generally not protected by a testimonial privilege."[92] It surmised, "There would be no reasonable expectation of confidentiality, and therefore no confidential intent, if a party to a conversation was aware that the other party may report on the conversation to a third party."[93] Finally, the court noted that the important element of evidentiary privilege is the "intent to keep a communication confidential."[94]

In *Estate of Turnbow v. Ogden City*,[95] a police officer submitted to a mental health evaluation as part of his application for employment as a police officer.[96] The court concluded that "the psychotherapist-patient privilege [did] not apply"—because the officer "knew that his evaluation would be disclosed as part of the application process, he could not have had a reasonable expectation that the communications would be kept private."[97]

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84. *See* Nelken, *supra* note 79, at 12–13. Coincidentally, many of these cases have a commonality with the facts of *Jaffee*, where the privileged communication came from a police officer's mandated therapy sessions after a self-defense shooting on the job.

85. 182 F.R.D. 597 (E.D. Mo. 1998).

86. *Id.* at 599. The court held that a patient cannot invoke privilege in the absence of intended confidential communications. *Id.*

87. *Id.*

88. *Id.*

89. 182 F.R.D. 177 (W.D. Pa. 1998).

90. *Id.* at 181.

91. *Id.* at 178.

92. *Id.* at 179.

93. *Id.*

94. *Id.*

95. 254 F.R.D. 434 (D. Utah 2008).

96. *Id.* at 437.

97. *Id.* at 437–38. Similarly, the U.S. District Court for the Southern District of Ohio found no privilege existed where a police officer's communications to a psychotherapist were not confidential in *Phelps v. Coy*, 194 F.R.D. 606, 608 (S.D. Ohio 2000). It is not clear from the opinion just how the officer came to expect that the communication would be shared with his employer. Instead, the court decided there was no privilege based on the fact that the communications were disclosed to his employer and, thus, were not confidential. *Id.*

Two other officers' records were also analyzed for privilege in this case.[98] The court decided privilege did not apply because they knew their evaluations would be shared with a third party.[99]

Lastly, in *Scott v. Edinburg*,[100] no privilege existed where the police officer was informed that his psychotherapy evaluation would be shared with his police chief and could potentially be subpoenaed in litigation proceedings.[101] In fact, the officer demonstrated his understanding of the limited confidentiality when he refrained entirely from making certain statements during the therapy and explained that it was because he knew the interview would not be kept confidential.[102] The court concluded that, because the officer "failed to establish the expectation of confidentiality that is the prerequisite for the existence of the psychotherapist-patient privilege, the privilege was never established."[103] The court also held that, even if there was privilege in the information disclosed to the therapist, the patient had waived the privilege by his knowledge that it would be disclosed to a third party.[104]

The four cases discussed above "suggest that the psychotherapist-patient privilege will apply to mandatory post-shooting therapists' evaluations *if* the patient held a reasonable expectation of privacy before starting the therapy or evaluation."[105] Indeed, "[t]he determinative factor assessing the existence of a psychotherapist-patient privilege is whether an officer had a reasonable expectation of confidentiality relating to the post-incident counseling session or evaluation."[106] More generally, "[t]he consistent thread that runs through all of these cases is that the threshold requirement for the existence of the psychotherapist patient privilege is that there be an expectation by the patient that the communications with the psychotherapist will remain with the psychotherapist and will not be disclosed to others."[107]

These four cases contrast with other cases, in which the officers fully expected their communications during psychotherapy to remain confidential. For example, in *Williams v. District of Columbia*,[108] the police officer could assert privilege regarding his employer-mandated

(citing United States v. Hubbard, 16 F.3d 694, 697 (6th Cir. 1994), *rev'd on other grounds*, 514 U.S. 695 (1995)).

98. *Estate of Turnbow*, 254 F.R.D. at 438.

99. *Id.*

100. 101 F. Supp. 2d 1017 (N.D. Ill. 2000).

101. *Id.* at 1020.

102. *Id.*

103. *Id.* at 1020–21.

104. *Id.* at 1021. This case is an instructive example of the tenuous line between determinations that no privilege exists and that the privilege was waived. *See supra* notes 38–43 and accompanying text.

105. James v. Harris County, 237 F.R.D. 606, 611 (S.D. Tex. 2006) (distinguishing the four cases from the facts of its case because the officer fully expected his communication with a psychotherapist to remain private).

106. *Id.* at 611–12.

107. *Scott*, 101 F. Supp. 2d at 1020.

108. No. Civ. A. 96-0200-LFO, 1997 WL 224921 (D.D.C. Apr. 25, 1997).

psychotherapy evaluation because he had understood that the therapist would not share the confidential communications of the evaluation with his employer, as per District of Columbia Police Department policy.[109] In this case, the therapist was only permitted to disclose whether the officer was fit to return to duty.[110]

Similarly, in *Caver v. City of Trenton*,[111] the psychotherapist specifically told and reassured the officer that the records resulting from his psychological evaluation would remain strictly confidential.[112] The officer understood that the therapist would only disclose a general conclusion regarding his fitness for work.[113] The court determined that the officer clearly had an expectation of confidentiality and that, therefore, his communications were privileged.[114] Alternatively, this court went further, holding that even if the psychotherapist-patient privilege did not apply, the court would have granted a protective order to shield the records from disclosure, on grounds that "disclosure would chill the candor between the police officer and the psychologist necessary for effective diagnosis and evaluation."[115]

Lastly, in *James v. Harris County*,[116] the police officer signed a release before he started the first counseling session, however he did not initial his agreement to the disclosure of any treatment or diagnosis information.[117] Therefore, the officer did not expect or authorize the therapist to disclose information other than his attendance in the therapy.[118] In fact, the psychotherapist told the officer before the sessions began that the

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109. *Id.* at *2.

110. *Id.*

111. 192 F.R.D. 154 (D.N.J. 2000).

112. *Id.* at 162.

113. *Id.*

114. *See id.*; *see also* Speaker v. County of San Bernardino, 82 F. Supp. 2d 1105, 1117 (C.D. Cal. 2000) (A police officer "had a clear expectation of confidentiality regarding his conversations" with a mental health counselor during a mandatory evaluation when his employer specifically told him that his communication would be kept confidential.).

115. *Caver*, 192 F.R.D. at 163. In more detail, the court held,

> This testing is performed not only to benefit the officer's mental well-being, but more importantly, to ensure the safety of the community by protecting its citizens from police officers whose mental instability poses a risk to public safety. If police officers know that their psychological records may be disclosed to the public, there exists a likelihood that they would not be completely candid when speaking to a mental health professional. This lack of candor would, in turn, defeat the purpose for psychological evaluations, which is, determining mental fitness for the job. The Court recognizes that the public has an interest in knowing whether their police are mentally fit for the job, but disclosure of actual psychological records is not necessary and would have a chilling effect on frankness between patient and psychologist. If police officers are not completely honest when speaking to a mental health professional, it will make it more difficult for the mental health professional to accurately evaluate the mental status of a police officer, and to ensure public safety.

Id.

116. 237 F.R.D. 606 (S.D. Tex. 2006).

117. *Id.* at 607.

118. *Id.* at 612.

communications in the course of the counseling would remain private.[119] The court determined that privilege existed because the officer intended the counseling sessions to be confidential and never intended to waive the privilege.[120]

In each of these cases, *Williams*, *Caver*, and *James*, the police officers were assured of the absolute confidentiality at the start of their employer-mandated therapy.[121] Thus, their communications to the therapists were privileged.[122] Although these cases do not deal with *Tarasoff* warnings, they are relevant to this discussion insomuch as they involve advisories to the patients about the limits of confidentiality and the consequences these advisories have on the status of privilege.[123]

Finally, in the unreported case of *United States v. Whitney*,[124] the U.S. District Court for the District of Massachusetts decided the status of privilege of communication made in a court-mandated psychiatric evaluation for a commitment hearing.[125] In *Whitney*, an adult defendant who had pled guilty to federal drug trafficking charges, but was not yet sentenced, underwent a psychiatric evaluation to determine if civil commitment was appropriate.[126] The government wanted to introduce the defendant's Department of Youth Service (DYS) psychiatric records, which included information about his mandated seven-year custody for committing sexual assault on two young boys.[127] The district court recognized that under Massachusetts law, the state psychotherapist-patient privilege could attach to court-ordered psychiatric interviews, unless the interviewee was advised otherwise.[128] In *Whitney*, the defendant was given "*Lamb*" warnings on eight occasions referenced in his state psychiatric records, although each was framed in slightly different terms.[129] These warnings advise the "patient that the interview will be disclosed to court personnel and will not remain confidential."[130]

At his commitment hearing, the defendant opposed release of his DYS psychiatric records on the grounds that he was told the information would only be used for the DYS evaluation of his custody term—"not that the

119. *Id.*
120. *Id.*
121. *See supra* notes 109, 112–13, 119 and accompanying text.
122. *See supra* notes 105, 109, 114, 120 and accompanying text.
123. *See infra* Part III.A.
124. No. 05-40005-FDS, 2006 WL 2927531 (D. Mass. Aug. 11, 2006).
125. *Id.* at *1.
126. *Id.*
127. *Id.*
128. *Id.* at *3 (citing MASS. GEN. LAWS ch. 233, § 20 B(b); Commonwealth v. Lamb, 311 N.E.2d 47, 50 (Mass. 1974)).
129. *Id.* at *3 n.2 (recognizing it is commonplace to see evidence of "Lamb" warnings, also referred to as "lack of confidentiality warnings," in DYS records). In *Commonwealth v. Lamb*, the Supreme Court of Massachusetts established that a patient's communications are privileged to a court-appointed psychotherapist for a court-ordered examination, "absent a showing that he was informed that the communication would not be privileged and thus, inferentially, that it would be used at the commitment hearing." *Lamb*, 311 N.E.2d at 51.
130. *Whitney*, 2006 WL 2927531, at *3 n.2.

information would lose its confidential nature entirely."[131] The *Whitney* court stated it was irrelevant because "[e]ither a communication is privileged from the outset, or it is not."[132] The court further held, "If the communication is not intended to be kept confidential between the psychotherapist and the patient, it is not privileged, even if the patient did not understand the full implications of that lack of confidentiality."[133] Thus, as a result of the administered *Lamb* warnings, which informed him not to expect confidentiality, the court held that the defendant's communications to a psychotherapist when he was in DYS custody were not privileged.[134] The *Whitney* decision is analogous to the holdings of *Kamper*, *Barrett*, *Estate of Turnbow*, and *Scott*, discussed in this Part *supra*, which involved police officers who underwent mandatory psychiatric evaluations but were first advised about what information would be kept confidential.

b. *Waiver Doctrine Applied to the Psychotherapist-Patient Privilege*

The Supreme Court noted in *Jaffee* that "[l]ike other testimonial privileges, the patient may of course waive the protection."[135] However, the Court declined to delineate under what specific conditions the privilege may be waived.[136]

Since *Jaffee*, case law regarding waiver of the psychotherapist-patient privilege has evolved in several ways. Generally, "[p]atients may waive the privilege explicitly by their words or actions or implicitly by making nonconfidential disclosures of the same information."[137] For example, a patient explicitly waives privilege when he places his mental health at issue in a litigation suit.[138] A patient also waives privilege if he allows his mental health records to become publicly available.[139] Generally, there is no privilege if a third party is present during a communication in therapy between a patient and his psychotherapist.[140]

There can also be waiver of privilege if the patient has made a prior disclosure of the same information to a third party. In *United States v.*

131. *Id.*
132. *Id.*
133. *Id.*
134. *Id.* at *4. The court also determined that the circumstances of this case were particularly appropriate to construe the privilege narrowly "where the stakes are quite high for the defendant (who faces the possibility of extended confinement) and the public (which faces the possibility of premature release of a potentially dangerous person)." *Id.*
135. Jaffee v. Redmond, 518 U.S. 1, 15 n.14 (1996).
136. *Id.* at 18; *see* Smith, *supra* note 19, at 101.
137. *See* KNAPP & VANDECREEK, *supra* note 29, at 11.
138. *Id.* at 64; *see Developments in the Law—Privileged Communications*, *supra* note 46, at 1537 (discussing the patient-litigant exception as a waiver); *see, e.g.*, Doe v. Oberweis Dairy, 456 F.3d 704, 718 (7th Cir. 2006); Schoffstall v. Henderson, 223 F.3d 818, 823 (8th Cir. 2000); Green v. St. Vincent's Med. Ctr., 252 F.R.D. 125, 127–28 (D. Conn. 2008).
139. Pearson v. Miller, 211 F.3d 57, 70 (3d Cir. 2000).
140. ROBERT I. SIMON, CONCISE GUIDE TO PSYCHIATRY AND LAW FOR CLINICIANS 53–54 (3d ed. 2001).

Bishop,[141] the U.S. Court of Appeals for the Sixth Circuit determined that the patient waived privilege because the patient had previously made disclosure of the same communication to an investigative agent during an interview.[142] Two years later, this same court decided *United States v. Hayes*,[143] holding that once a patient receives an advisory from his psychotherapist, a subsequent threat would still be confidential because continued communication following the therapist's *Tarasoff* warning does not amount to a waiver of privilege.[144]

The distinction between communication that does not originate with the expectation of confidentiality and confidential communication that is waived can be subtle. In *United States v. Wimberly*,[145] the U.S. Court of Appeals for the Seventh Circuit held that a patient knowingly and voluntarily waived privilege when, before undergoing counseling, he signed a waiver stating that he understood that state law severely limits confidentiality in cases involving child abuse and that therapists would be required by law to report cases of known or suspected child abuse to local authorities.[146] Oftentimes, when privilege has been determined to attach to confidential communications, there is a waiver analysis.[147] For example, in *Whitney*, the court concluded that the defendant, despite being a minor, could waive privilege, since he "was certainly capable of understanding a warning that information he revealed to a psychotherapist would not remain confidential."[148]

5. Determining the Scope of the Federal Psychotherapist-Patient Privilege: Exceptions

Because *Jaffee* was the first case in which the Supreme Court established a federal psychiatrist-patient privilege, the Court found it "neither necessary nor feasible to delineate its full contours in a way that would 'govern all conceivable future questions in this area.'"[149] In dicta found in footnote nineteen, the Court left open the possibility of whether there is an exception to this privilege:

> Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for

141. United States v. Bishop, 149 F.3d 1185 (6th Cir. 1998) (unpublished table decision), No. 97-1175, 1998 WL 385898 (July 1, 1998).
142. *Bishop*, 1998 WL 385898 at *5.
143. 227 F.3d 578 (6th Cir. 2000).
144. *See infra* Part II.B.1.b (discussing *United States v. Hayes*).
145. 60 F.3d 281 (7th Cir. 1995).
146. *Id.* at 285 & n.2.
147. *See* Smith, *supra* note 19, at 106.
148. No. 05-40005-FDS, 2006 WL 2927531, at *4 (D. Mass. Aug. 11, 2006).
149. Jaffee v. Redmond, 518 U.S. 1, 18 (1996) (quoting Upjohn Co. v. United States, 449 U.S. 383, 386 (1996)).

> example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.[150]

The Court elaborated no further as to the situation in which privilege would "give way" other than this one statement tucked in a footnote; thus, its meaning has drawn much speculation and controversy as to what kind of situations warrant exceptions to the privilege.[151] The decision of *Jaffee* appears to "contemplate[] that the so-called 'absolute' privilege which it has created must 'give way' in certain situations based upon the *content* of the communication."[152] Presumably these content-based exceptions were to evolve as part of the development of the psychotherapist privilege, as the result of judges examining the contents of the communication and assessing the potential harm that would result from not disclosing.[153] A few federal courts have used footnote nineteen as justification for what has been called the "dangerous-patient exception" to the privilege.[154] The dangerous-patient exception means that the privilege between psychotherapist and patient disappears if it can be proven that the threat was serious at the time the patient uttered it and if the *Tarasoff*-required warning made by the psychotherapist was the only way to avert harm to the third party at risk.[155]

The recognition of an exception is significant because it means "otherwise privileged information will be subject to disclosure."[156] Furthermore, the distinction between an exception and other "situations in which the privilege either does not attach (e.g., when a communication was not intended to be confidential) or has been waived (e.g., by voluntary disclosure of a confidential communication)" is vital to the framing of certain facts and the consequences of privilege.[157] Indeed, the distinction is a delicate one. One commentator points out that even "courts do not always observe the[] linguistic distinctions."[158]

Like other established privileges, there are few exceptions to the federal psychotherapist privilege.[159] Broadly defined exceptions would take away the certainty of how privilege is applied and undermine policies grounding

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150. *Id.* at 18 n.19.

151. *See* Paul S. Appelbaum, *Law & Psychiatry: Privilege in the Federal Courts: Should There Be a "Dangerous Patient Exception"?*, 59 PSYCHIATRIC SERVICES 714, 714 (2008); *cf.* Smith, *supra* note 19, at 101.

152. Glen Weissenberger, *The Psychotherapist Privilege and the Supreme Court's Misplaced Reliance on State Legislatures*, 49 HASTINGS L.J. 999, 1006 (1998).

153. *Id.*

154. *See infra* Part II.A (discussing federal circuit cases applying the dangerous-patient exception); *infra* Part II.B (addressing circuit cases that oppose this interpretation of *Jaffee*'s footnote nineteen).

155. *See* United States v. Chase, 340 F.3d 978, 984 (9th Cir. 2003) (en banc) (citing United States v. Glass, 133 F.3d 1356, 1357 (10th Cir. 1998)).

156. Nelken, *supra* note 79, at 18.

157. *Id.*

158. *Id.* (discussing, as an example, how some courts often refer to an "implied waiver" of the privilege—such as when a party makes a claim for emotional distress damages—where the courts are actually recognizing an exception to privilege).

159. *Id.*

the privilege.[160] The following exceptions to the psychotherapist-patient privilege have evolved in common law: the patient-litigant exception (although this is also framed in terms of waiver doctrine),[161] the crime-fraud exception,[162] and the dangerous-patient exception.[163]

In fact, there is a preference to apply a narrow definition of privilege,[164] rather than create new exceptions, for it is generally understood "'that in seeking access to allegedly privileged material, the exceptions are a last resort; most privilege claims are defeated by a rigorous application of the terms of the privilege, not by invocation of an exception.'"[165]

B. *Psychotherapists'* Tarasoff *Duty To Warn Third Parties*

Most states have laws that require a psychotherapist to disclose a dangerous patient's confidential communications when the disclosure would avert harm to potential victims of the patient.[166] Part I.B.1 and Part I.B.2 explain the origins and development of what has come to be known as a psychotherapist's *Tarasoff* duty. Part I.B.3 discusses how psychotherapists reconcile the legal duty to provide a *Tarasoff* warning to third parties with their ethical (and concurrent legal) obligation to maintain the confidentiality that patients expect. In fact, when psychotherapists are faced with the ethico-legal choice between protecting the safety of others and maintaining the trust of a patient, many psychotherapists choose to reconcile these divergent interests by informing patients of the limits of confidentiality, which may include an advisory to patients about the psychotherapists' *Tarasoff* duty. Part I.B.3 explores how psychotherapists typically handle giving such advisories to patients with respect to the timing and specificity. Lastly, this Part investigates possible effects that such advisories have upon the treatment relationship.

1. *Tarasoff v. Regents of the University of California*

Over thirty years have passed since the landmark case of *Tarasoff v. Regents of the University of California*.[167] Indeed, this state case predated

160. *Id.* (citing Jaffee v. Redmond, 518 U.S. 1, 10–11 (1996)).

161. *See supra* note 138 and accompanying text.

162. *See, e.g.*, *In re* Grand Jury Proceedings (Gregory P. Violette), 183 F.3d 71, 73–79 (1st Cir. 1999).

163. *See infra* Part II.A.

164. *See* United States v. Whitney, No. 05-40005-FDS, 2006 WL 2927531, at *4 (D. Mass. Aug. 11, 2006) (citing United States v. Roberson, 859 F.2d 1376, 1378 (9th Cir. 1988); Trammel v. United States, 445 U.S. 40, 50 (1980)) (deciding to construe privilege strictly by holding a patient's communication was not privileged since he was capable of understanding a warning that information revealed to a psychotherapist would not remain confidential).

165. Nelken, *supra* note 79, at 18 n.79 (quoting 24 CHARLES ALAN WRIGHT & KENNETH W. GRAHAM, FEDERAL PRACTICE AND PROCEDURE § 5501, at 493 (1989)).

166. George C. Harris, *The Dangerous Patient Exception to the Psychotherapist-Patient Privilege: The* Tarasoff *Duty and the* Jaffee *Footnote*, 74 WASH. L. REV. 33, 46 (1999).

167. 551 P.2d 334 (Cal. 1976).

the Supreme Court's establishment of a federal psychotherapist-patient privilege by two decades.[168] *Tarasoff* was the first case to recognize an affirmative legal obligation on the part of a psychotherapist to protect a third party who is in serious danger of violence from a patient in his treatment.[169] A *Tarasoff* duty means that "once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."[170] The general scope of this duty is that a psychotherapist should either advise law enforcement about his patient's threat of violence or assume a duty to protect by warning the third party directly.[171] Although the ethical obligation of patient confidentiality is of great importance, a *Tarasoff* duty is supposed to make violation of confidentiality acceptable on public policy grounds.[172] The Supreme Court of California concluded that "the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins."[173] This legal duty to warn is significant because it mandates disclosure without regard to the patient's wishes to maintain confidentiality.[174] Failure to observe this duty can lead to liability on the part of the psychotherapist and possibly professional disciplinary proceedings.[175]

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168. *Compare id.*, *with* Jaffee v. Redmond, 518 U.S. 1 (1996).

169. *Tarasoff*, 551 P.2d at 345.

170. *Id.*

171. In fact, the Supreme Court of California heard the *Tarasoff* case twice. The first opinion held that a psychotherapist has a duty to warn. Tarasoff v. Regents of the Univ. of Cal., 529 P.2d 553, 555 (Cal. 1974). This opinion was then vacated eighteen months later, and the court replaced the duty to warn with a broader duty to protect. *Tarasoff*, 551 P.2d 334, 340 (Cal. 1976). Although many commentators have tied significance to this linguistic overhaul, others believe "the earlier phrase was accurate, [while] the later one rhetorical and misleading." Herbert & Young, *supra* note 5, at 275. Illustrative of this argument is the fact that California's statute that supersedes the *Tarasoff* decision "couch[es] the duty exclusively in terms of warning." *Id.* In actuality, the text of the statute seems to incorporate both concepts. *See* CAL. CIV. CODE § 43.92 (West 1985) (amended 2006) ("(a) There shall be no monetary liability on the part of . . . a psychotherapist . . . in *failing to warn of and protect* from a patient's threatened violent behavior *or failing to predict and warn of and protect* from a patient's violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims. (b) There shall be no monetary liability on the part of . . . a psychotherapist who, under the limited circumstances specified above, discharges his or her *duty to warn and protect* by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency." (emphasis added)).

172. *Tarasoff*, 551 P.2d at 347; *see* Herbert & Young, *supra* note 5, at 275 ("The core innovation of *Tarasoff* was the creation of a new exception to psychotherapist-patient confidentiality.").

173. *Tarasoff*, 551 P.2d at 347.

174. *See* Paul W. Mosher & Peter P. Swire, *The Ethical and Legal Implications of* Jaffee v. Redmond *and the HIPAA Medical Privacy Rule for Psychotherapy and General Psychiatry*, 25 PSYCHIATRIC CLINICS N. AM., 575, 580 (2002).

175. *See id.* at 580–81.

2. State *Tarasoff*-Model Laws

Within a decade after the *Tarasoff* decision, the "duty to warn" became law in most states and also became an integral part of mental health professional training and practice.[176] The *Tarasoff* decision triggered a wave of similar court decisions and statutory enactments throughout other states, although with significant variations.[177] Most states have limited the duty to warn to situations where the patient makes a specific and serious threat to an identifiable victim.[178] The psychotherapist is typically required to notify the potential victim, the police, or both.[179] About half of states impose a mandatory duty to warn, although the contours of the duty still vary considerably.[180] Many other states give psychotherapists discretionary permission to warn third parties about the patient's threat, rather than

176. *See* Herbert & Young, *supra* note 5, at 275–76.

177. *See* PAUL S. APPELBAUM, ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE 96 (1994); *see also* Herbert & Young, *supra* note 5, at 277 (describing the results of a thorough state survey and concluding that variance is "a function, in part, of variability in the quality of legislative craftsmanship and, in part, presumably, owing to quite disparate levels of basic enthusiasm for the duty-to-warn principle").

178. RALPH SLOVENKO, PSYCHOTHERAPY AND CONFIDENTIALITY: TESTIMONIAL PRIVILEGED COMMUNICATION, BREACH OF CONFIDENTIALITY, AND REPORTING DUTIES 285 (1998); *see* Alan R. Felthous, *Warning a Potential Victim of a Person's Dangerousness: Clinician's Duty or Victim's Right?*, 34 J. AM. ACAD. PSYCHIATRY & L. 338, 341 (2006) (comparing statutes that use the words "serious," "actual," "immediate," and "specific [and] serious") (alteration in original); *see, e.g.*, CAL. CIV. CODE § 43.92 (West 1985) (amended 2006) (psychotherapist not subject to liability "where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim" and the therapist discharges his duty to warn by "making reasonable efforts to communicate the threat to the victim . . . and to a law enforcement agency"); MONT. CODE ANN. § 27-1-1102 (2007) (psychotherapist "has a duty to warn of or take reasonable precautions to provide protection from violent behavior only if the patient has communicated to [him] an actual threat of physical violence by specific means against a clearly identified or reasonably identifiable victim").

179. *See* Herbert & Young, *supra* note 5, at 277–78 (noting about half of the states that recognize a duty to warn require both prompt warnings to the police and reasonable attempts to warn a potential victim, while others mandate that victims are warned, provide a choice, or require notification to the police if the victim cannot be reached).

180. *See id.* (citing statutory law from twenty-three states and case law from four states, all mandating a *Tarasoff* duty applicable to psychotherapists); *cf.* Claudia Kachigian & Alan R. Felthous, *Court Responses to* Tarasoff *Statutes*, 32 J. AM. ACAD. PSYCHIATRY & L. 263, 265 (2004) (citing statutory law of seventeen states that explicitly establish a duty to warn or conditionally establish a duty to warn under specified circumstances). Of course, the determination of whether a statute mandates a *Tarasoff* warning or permits discretion may be ambiguous. *Compare* Kachigian & Felthous, *supra* note 180, at 265 & n.14 (deeming the *Mississippi Tarasoff* statute permissive), *with* Herbert & Young, *supra* note 5, at 277 n.27 (describing the same Mississippi statute as "containing both mandatory and permissive language"). The Mississippi statute states, "[W]hen the patient has communicated . . . an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim . . . then the treating physician, psychologist . . . , master social worker or licensed professional counselor may communicate the threat only to the potential victim or victims, a law enforcement agency, or the parent or guardian of a minor who is identified as a potential victim." MISS. CODE ANN. § 41-21-97(e) (West 1991) (amended 2008).

explicitly imposing a mandatory duty to warn.[181] A few states still have no definitive law on the issue.[182] Also, most of the laws differ regarding to whom they apply (e.g., psychiatrists, psychologists, social workers, nurses, social counselors, marriage counselors, or even music therapists).[183] It seems that "the variety of duty-to-warn laws across the nation—with no two states agreeing precisely on a common approach—is virtually unprecedented for any widespread legal doctrine."[184]

Because of these statutory variations and the added layer of judicial interpretation of these statutes[185]—not to mention the gnawing ethical dilemma of breaching patient confidentiality if a *Tarasoff* warning is necessary—it is no surprise that psychotherapists are confused about their duty.[186] As a result, "the safest (actually and legally) and simplest course is both to notify law enforcement and to document reasonable and prompt attempts to warn the potential victim."[187] Even in states where a *Tarasoff* warning is discretionary,[188] psychotherapists may be advised to treat *Tarasoff* warnings as a legally required duty out of prudence and as a precaution to avoid tortious liability.[189] This advice would seem to extend even to the states that have no *Tarasoff* laws.[190]

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181. *See* Herbert & Young, *supra* note 5, at 278–79 (citing statutory law from nine states and the District of Columbia); Kachigian & Felthous, *supra* note 180 (citing statutory law of only two states, categorized as "permissive" and applicable to psychiatrists). Under state laws where *Tarasoff* warnings are categorized as permissive, a psychotherapist will not be liable if the therapist wants to maintain the sanctity of confidentiality or is unconvinced the threat is serious, and therefore chooses to remain silent. Herbert & Young, *supra* note 5, at 277–80.

182. Herbert & Young, *supra* note 5, at 280.

183. *Id.* at 277–78.

184. *Id.* at 280; *see* Yvona L. Pabian, Elizabeth Welfel & Ronald S. Beebe, *Psychologists' Knowledge of Their States' Laws Pertaining to* Tarasoff-*Type Situations*, 40 PROF. PSYCHOL.: RES. & PRAC. 8, 9 (2009).

185. Herbert & Young, *supra* note 5, at 276.

186. *See* SLOVENKO, *supra* note 178, at 285 (citing ALAN R. FELTHOUS, THE PSYCHOTHERAPIST'S DUTY TO WARN OR PROTECT (1989)); *see also* Fillmore Buckner & Marvin Firestone, *"Where the Public Peril Begins": 25 Years After* Tarasoff, 21 J. LEGAL MED. 187, 216 (2000); Paul B. Herbert, *Commentary: Ethics and Law at the Bar and on the Couch*, 32 J. AM. ACAD. PSYCHIATRY & L. 274, 275 (2004); Kachigian & Felthous, *supra* note 180, at 271 ("Conceivably many clinicians and attorneys alike are more familiar with the celebrated *Tarasoff* case itself than with the jurisdictional statutory law."); Pabian, Welfel & Beebe, *supra* note 184, at 8 (finding 76.4% of surveyed psychologists "were misinformed about their state [*Tarasoff*] laws, [either] believing that they had a legal duty to warn when they did not, or assuming that warning was their only legal option when other protective" measures would have been acceptable); Anton O. Tolman, *Clinical Training and the Duty To Protect*, 19 BEHAV. SCI. & L. 387, 392 (2001) (explaining new and veteran clinicians primarily experience anxiety about a *Tarasoff* duty because of confusion and concern about the scope of the law and also "the concern about going outside the normal boundaries of confidentiality").

187. *See* Herbert & Young, *supra* note 5, at 278.

188. *See supra* note 181.

189. *See* Herbert & Young, *supra* note 5, at 279.

190. *Id.* at 277 ("[P]sychotherapists can never rest fully assured that a court decision will not abruptly alter their obligations . . . as occurred in *Tarasoff* itself.").

And yet, because of this cautionary advice, defensive psychotherapy is also a concern, where practitioner therapists may be so worried about liability that they lose sight of the patient's best interest. For example, the *Concise Guide to Psychiatry and Law for Clinicians* advises psychotherapists against consulting with a lawyer who may be overly risk-adverse.[191] It also warns psychotherapists not to become fixated upon their *Tarasoff* duty at the expense of ignoring other more effective clinical intervention techniques that work for the great majority of potentially violent patients.[192]

Although a *Tarasoff* duty to warn may be legally required in certain situations, there is also a wide array of options for psychotherapists to consider in order to reduce the risk that harm will be realized, including hospitalization, more frequent therapy sessions or special sessions involving the patient's family or the target of the threat, medications, closer monitoring, or removal of dangerous weapons.[193] Doctors Fillmore Buckner and Marvin Firestone suggest that "[b]efore breaching confidentiality, all therapeutic approaches must be considered by therapist and patient."[194] "Only if such efforts seem unlikely to provide adequate protection should confidentiality be breached, and then only after advising the patient of the plan."[195] The *Concise Guide to Psychiatry and Law for Clinicians* also recommends that a *Tarasoff* warning should be used as a "last resort," although it should certainly not be ignored if it is required.[196]

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191. *See* SIMON, *supra* note 140, at 200 (explaining that defensive psychiatry may abuse the patient's rights and "unduly traumatize[]" potential victims); *see also* Felthous, *supra* note 178, at 339 ("Clinicians are advised to familiarize themselves with the laws in their jurisdiction and, especially when confusion exists, to consult with a mental health attorney.").

192. *See* SIMON, *supra* note 140, at 200. In fact, there is an overwhelming voice in the psychotherapy profession that argues *Tarasoff* duties should only be discretionary. *See, e.g.*, CHRISTOPHER BOLLAS & DAVID SUNDELSON, THE NEW INFORMANTS: THE BETRAYAL OF CONFIDENTIALITY IN PSYCHOANALYSIS AND PSYCHOTHERAPY (1995); Herbert, *supra* note 186, at 275 (arguing passionately that violence prevention is police work and "not the responsibility nor within the professional competence of psychiatrists").

193. *See* Buckner & Firestone, *supra* note 186, at 221; *see also* APPELBAUM, *supra* note 177, at 98; Dale E. McNiel, Renée L. Binder & Forrest M. Fulton, *Management of Threats of Violence Under California's Duty-To-Protect Statute*, 155 AM. J. PSYCHIATRY 1097, 1099 (1998) (noting in its survey of reported *Tarasoff* warnings in San Francisco that "most therapists in [the] study appear[ed] to have used other methods to protect the victims of their patients' threats than the mechanism in [California's] duty-to-protect statute"). In the latter article, the authors acknowledge that in these cases, if the danger did not acquiesce when the psychotherapist pursued involuntary hospitalization, increased outpatient service, or other alternative intervention, then the psychotherapist could have been teeing himself up for liability. *Id.*

194. Buckner & Firestone, *supra* note 186, at 221.

195. *Id.*

196. SIMON, *supra* note 140, at 200; *see* RICHARD L. BEDNAR ET AL., PSYCHOTHERAPY WITH HIGH-RISK CLIENTS: LEGAL AND PROFESSIONAL STANDARDS 77–78 & tbl.4-4 (1991); KNAPP & VANDECREEK, *supra* note 29, at 154 ("The duty to warn applies only when the psychotherapist has determined that other options are not viable.").

3. Advising Patients of the *Tarasoff* Duty: Informed Consent?

A *Tarasoff* duty breaks the alliance of trust to some degree, since "[t]he therapist is forced into the position of social agent, both by law, and more importantly, by the overriding concern for the safety of the patient and others."[197] As a result, "[p]sychotherapists feel that they are between a rock and a hard place" in choosing between the obligation to ensure the confidentiality that patients expect and the duty to warn endangered third parties.[198]

In fact, "confidentiality is a protection often assumed by patients to be total, but known by therapists to be severely limited."[199] "Confidentiality is based on professional ethics and indicates a promise to reveal nothing about clients without their consent or as allowed by law."[200] At the beginning of the treatment relationship, an implied contract is created between psychotherapist and patient,[201] and as a result, patients anticipate confidentiality.[202] Under this implied contract theory, scholars argue that psychotherapists should inform patients about any change in the contract regarding confidentiality because patients "have a right to be informed whenever their secrets are endangered through their own actions (threats to others), through the actions of their therapists . . . or through the actions of other parties . . . ."[203] Thus, an advisory to a patient about a psychotherapist's *Tarasoff* duty is an attempt by the psychotherapist to act

197. GUTHEIL & APPELBAUM, *supra* note 74, at 18.

198. SLOVENKO, *supra* note 178, at 284; *see* Daniel W. Shuman & William Foote, Jaffee v. Redmond*'s Impact: Life After the Supreme Court's Recognition of a Psychotherapist-Patient Privilege*, 30 PROF. PSYCHOL.: RES. & PRAC. 479, 484 (1999).

199. SLOVENKO, *supra* note 178, at 291.

200. KNAPP & VANDECREEK, *supra* note 29, at 141.

201. *See supra* note 75 and accompanying text.

202. *See* KNAPP & VANDECREEK, *supra* note 29, at 142 (citing Appelbaum et al., *supra* note 77; Schmid et al., *supra* note 77); *see also* Elmer D. Abbo & Angelo E. Volandes, *Rare But Routine: The Physician's Obligation To Protect Third Parties*, 6 AM. J. BIOETHICS 34, 35 (2006) (explaining that the rules of confidentiality, despite often being tacit, are usually well understood by doctors and patients and "silence in fact implies general acceptance by both patients and physicians").

203. KNAPP & VANDECREEK, *supra* note 29, at 142; *see* BERNARD LO, RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS 315 (2d ed. 2000) (citing Paul S. Appelbaum, Tarasoff *and the Clinician: Problems in Fulfilling the Duty To Protect*, 142 AM. J. PSYCHIATRY 425 (1985)); *see also* Mary Alice Fisher, *Protecting Confidentiality Rights: The Need for an Ethical Practice Model*, 63 AM. PSYCHOLOGIST 1, 3 (2008) ("[I]f confidentiality will be conditional, clients have a right to be informed about the 'conditions' *before* they consent to confide, regardless of the clinical consequences of that conversation."); Shuman & Foote, *supra* note 198, at 483 ("Psychologists have an ethical duty to inform patients of the parameters of confidentiality in a way that recognizes what information realistically may be protected, and what may be subject to compelled disclosure."); Comment, *Evidence—Sixth Circuit Holds That* Tarasoff *Disclosures Do Not Vitiate Psychotherapist-Patient Privilege.*—United States v. Hayes, *227 F.3d 578 (6th Cir. 2000)*., 114 HARV. L. REV. 2194, 2199 (2001) ("[A] psychotherapist must warn his patient that credible statements regarding an intent to harm a third party cannot be kept confidential.") [hereinafter Comment, *Evidence*].

within his informed consent requirements, despite the patient's lack of choice regarding disclosure.[204]

At first blush, it seems puzzling why a psychotherapist would advise a patient about a *Tarasoff* duty under the guise of the informed consent doctrine, since it is a legally required disclosure that is really out of the hands of the patient.[205] Despite the premium placed on confidentiality within the psychotherapist-patient relationship, it appears that "[t]rust—not confidentiality—is the cornerstone of psychotherapy," because "[d]isclosing information about a patient without knowledge or consent would be a breach of trust."[206] Indeed, if a psychotherapist discusses his *Tarasoff* duty with a patient, it could strengthen the therapeutic relationship.[207] For example, it may dissuade the patient from acting on his threat, because the patient is made aware of the consequence of his actions if he follows through.[208] A patient's immediate reactions could help a therapist establish the seriousness of the threat and patient's level of determination to actually harm another.[209]

It is important to note that although psychotherapists have an obligation to maintain the patients' confidential treatment information, it is not legally required that the therapist inform the patient specifically about a *Tarasoff* duty. Courts typically hold that medical professionals do not have to disclose all risks of treatment, but only those risks that are generally disclosed in the customary practice within the professional community.[210] Thus, "whether therapists must disclose the possibility of warning potential victims depends in part upon whether therapists, in general, disclose this risk and upon the extent to which they disclose similar limitations upon

204. *See* BEDNAR ET AL., *supra* note 196, at 69 ("The only possible solution to this confusing and ambiguous state of affairs [regarding the psychotherapist's legal obligation to society and his concurrent ethical obligation to clients] is for all relevant parties to have the same understanding about the rules and expectations that govern therapeutic relationships.").

205. JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 308 (2d ed. 2001) ("[I]f because of the realities of a situation choice is not available, no informed consent procedure can create it.").

206. SLOVENKO, *supra* note 178, at 292.

207. *Id.* (citing James C. Beck, *When the Patient Threatens Violence: An Empirical Study of Clinical Practice After* Tarasoff, 10 BULL. AM. ACAD. PSYCHIATRY & L. 189 (1982)); *see* Shuman & Foote, *supra* note 198, at 485 (noting "research indicates that legally mandated disclosures are not always harmful to the therapeutic process"); *see, e.g.*, Beck, *supra* note 207, at 199–201 (survey study of a limited number of cases showed that *Tarasoff* warnings "seldom had an adverse effect on the therapeutic relationship," unless they were not discussed with the patient or were given without good reason).

208. APPELBAUM, *supra* note 177, at 97 (citing supportive case studies featured in Loren Roth & Alan Meisel, *Dangerousness, Confidentiality, and the Duty To Warn*, 134 AM. J. PSYCHIATRY 508, 510 (1977)).

209. *See* SLOVENKO, *supra* note 178, at 291.

210. George E. Dix, Tarasoff *and the Duty To Warn Potential Victims*, *in* LAW AND ETHICS IN THE PRACTICE OF PSYCHIATRY 118, 135 (Charles K. Hofling ed. 1981) (citing Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413; Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628 (1970)).

confidentiality."[211] Some psychotherapists may, of course, decide to withhold information from patients (such as the necessity of a *Tarasoff* duty) if they think that the disclosure would "cause the patient to forgo treatment or might increase the risk to the patient."[212]

Several associations involved in the practice of psychotherapy offer professional codes of conduct that recommend member-practitioners provide advisories to patients about the limits of confidentiality. Professional associations, such as the American Counseling Association, the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers, all advise their members to inform patients as to the limits of confidentiality, while also acknowledging that their members must fulfill the legally required duty to warn.[213] Studies show that many psychotherapists in practice do provide advisories about the *Tarasoff* duty to their patients.[214] One study, looking

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211. *Id.*

212. *Id.*; *see* SIMON, *supra* note 140, at 45 (stating that, although it is generally recommended that any limitations regarding the maintenance of confidentiality should be shared with the patient at the beginning of treatment, there is usually also therapeutic discretion in which a psychotherapist may be justified in withholding such information from the patient if the psychotherapist "can establish that disclosure would be detrimental to the patient").

213. *See, e.g.*, AM. COUNSELING ASS'N, CODE OF ETHICS § B, at 7 (2005) (comparing section B.1.d stating, "At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breached," with the "Danger and Legal Requirements" exception under section B.2.a., which recognizes that a "general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed"); AM. PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY § 4, at 6–7 (2009) (comparing section 4(2), which states, "A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion," and "[t]he continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy," with section 4(8), which states, "When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient"); NAT'L ASS'N OF SOC. WORKERS, CODE OF ETHICS 1 (2008) (comparing section 1.03(d), stating that even if patients are receiving psychotherapy services involuntarily, they should still be presented with the extent of the client's right to refuse, with section 1.07(c), stating that "[t]he general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person"); Am. Psychol. Ass'n, *Ethical Principles of Psychologists and Code of Conduct*, 57 AM. PSYCHOLOGIST 1060, 1066 (2002) (comparing section 4.02(a)'s standard about discussing the limits of confidentiality and section 4.02(b)'s encouragement to discuss the limits of confidentiality at the outset of the relationship and thereafter, unless it is not feasible, with section 4.05(b)(3)'s allowance for disclosure of "confidential information without the [patient's] consent . . . only as mandated by law, or where permitted by law for a valid purpose such as to . . . protect the client/patient, psychologist, or others from harm").

214. *See, e.g.*, James C. Beck, *Violent Patients and the* Tarasoff *Duty in Private Psychiatric Practice*, 13 J. PSYCHIATRY & L. 361, 368 (1985) (small survey of fifteen cases of Massachusetts psychiatrists treating dangerous patients showed psychiatrists discussed their *Tarasoff* duty with the patients, in seven of fifteen cases and did not discuss their

at cases where psychotherapists actually warned third parties, found that almost all surveyed therapists had discussed the *Tarasoff* duty with their patients.[215]

However, how psychotherapists should go about this *Tarasoff*-predicated advisory "can be a complicated process" that requires somewhat of a "balancing act."[216] For example, there is debate as to the optimal time for a psychotherapist to give such an advisory to the patient.[217] There is also some disagreement as to the content of such an advisory.[218] Lastly, there is much controversy regarding the effect of such advice upon patients' willingness to initially agree to or continue in therapy if they know that some communications will not be maintained in confidence.[219]

a. *The Timing of a Psychotherapist's Advisory to Patients About a* Tarasoff *Duty*

Some psychotherapists inform patients in advance by advising patients about the limits of confidentiality and what matters may warrant disclosure to third parties.[220] This is especially advisable when a therapist is treating a patient with a history of violence.[221] An advisory at the beginning of treatment "would aid in the assessment of dangerousness since any revelation made after such a warning ought to be taken seriously."[222] An alternative justification for an advisory at the beginning of treatment is based on fairness; without an informed consent conversation at the outset of

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Tarasoff duty in four of fifteen cases); Toni Pryor Wise, Note, *Where the Public Peril Begins: A Survey of Psychotherapists To Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165, 180 & n.82 (1978) (survey study of California psychotherapists in which 20.5% of respondents reported discussing confidentiality more frequently with patients after the *Tarasoff* decision, while 73.7% said they were doing it the same as before).

215. *See* Renée L. Binder & Dale E. McNiel, *Application of the* Tarasoff *Ruling and Its Effect on the Victim and the Therapeutic Relationship*, 47 PSYCHIATRIC SERVICES 1212, 1214 (1996). *But see* Dix, *supra* note 210, at 135–36 ("It is by no means clear that present practice [as of 1980] involves routine disclosure [to the patient] of the duty to warn.").

216. KNAPP & VANDECREEK, *supra* note 29, at 142.

217. *See infra* Part I.B.3.a.

218. *See infra* Part I.B.3.b.

219. *See infra* Part I.B.3.b.

220. KNAPP & VANDECREEK, *supra* note 29, at 154 (citing Charles L. Eger, Note, *Psychotherapists' Liability for Extrajudicial Breaches of Confidentiality*, 18 ARIZ. L. REV. 1061 (1976); John G. Fleming & Bruce Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025 (1974)); *see* SIMON, *supra* note 140, at 204; SLOVENKO, *supra* note 178, at 291–92; Gregory B. Leong, J. Arturo Silva & Robert Weinstock, *Ethical Considerations of Clinical Use of* Miranda*-Like Warnings*, 59 PSYCHIATRIC Q. 293, 293–94 (1988); *see also* KNAPP & VANDECREEK, *supra* note 29, at 155 (suggesting that psychotherapists "should make every effort to involve the client in the disclosure process, such as by obtaining consent and making the warning in the client's presence").

221. *See* LO, *supra* note 203, at 315 (citing GUTHEIL & APPELBAUM, *supra* note 74).

222. SLOVENKO, *supra* note 178, at 291.

treatment, "clients lose the right to make autonomous decisions about whether to enter the relationship and accept the confidentiality risks."[223]

Rather than preemptively addressing the consequences of a patient's serious threats, some therapists wait until a threat has actually been made and advise the patient before a warning to a third party takes place.[224] In fact, the often-recommended way for a psychotherapist to advise a patient about a *Tarasoff* duty is for the psychotherapist to inform the patient of his intention to act when the need "crystallizes."[225] Of course, the timing of an advisory is intertwined with its purpose. For example, Loren Roth and Alan Meisel recommend, based on case surveys, that once a patient begins to speak convincingly of potential violence, "[a]t this point it is advisable for the therapist to express alarm and explain the varying actions that might have to be taken if the patient persists in his threats."[226]

b. *The Specificity of an Advisory to Patients and Its Effect on the Treatment Relationship*

It is important to realize that the content of an advisory will have some impact on the patient relationship. Generally, it is not recommended for a psychotherapist to take a "pseudopreventive approach" by advising "patients (literally or in effect), 'Don't tell me about any . . . crimes you may intend to commit because I can't keep that confidential.'"[227] This may lead to a patient "independently (and erroneously) decid[ing] that a whole list of things are under the heading, 'Don't tell me.'"[228] Furthermore, such

223. Fisher, *supra* note 203, at 3. For psychotherapists treating dangerous patients, it "can be tempting to avoid discussion of the implications of some potential disclosures," but still the only way to ensure that a patient makes a well-informed choice is to provide important information before the decision to enter therapy. *Id.* at 9; *see* Colledge et al., *supra* note 56, at 10; Shuman & Foote, *supra* note 198 (citing Wesley B. Crenshaw & James W. Lichtenberg, *Child Abuse and the Limits of Confidentiality: Forwarning Practices*, 11 BEHAV. SCI. & L. 181 (1993)) ("It does little good to tell a patient that he or she has just revealed something that is now likely to be disclosed in court.")).

224. *See* SLOVENKO, *supra* note 178, at 292 ("Apparently, most therapists, though they do not inform their patients of the limits of confidentiality at the inception of treatment, will seek consent or at least advise the patient before disclosing any information to a potential victim or others."); *see also* APPELBAUM, *supra* note 177, at 98; Wise, *supra* note 214, at 176 & n.66 (reporting 14.5% of surveyed respondents discussed the limits of confidentiality at the outset of therapy, whereas 63.7% discussed it only if it came up in therapy.).

225. GUTHEIL & APPELBAUM, *supra* note 74, at 194; DANIEL W. SHUMAN & MYRON S. WEINER, THE PSYCHOTHERAPIST-PATIENT PRIVILEGE: A CRITICAL EXAMINATION 79–80 (1987) (referring to a 1978 California survey in which only eleven percent of respondents always discussed confidentiality with patients and "[m]ost discussed the limits of confidentiality only if the issue arose during treatment" (citing Wise, *supra* note 214)). Indeed, this occurred in the facts of several cases that will be discussed later. *See infra* Part II.

226. Roth & Meisel, *supra* note 208, at 510.

227. GUTHEIL & APPELBAUM, *supra* note 74, at 194–95.

228. *Id.* at 195. A variation of this scenario is where, in jurisdictions that require a *Tarasoff* duty only to readily identifiable third parties, psychotherapists may have incentive to put up a sign in the office stating, "Please don't identify people you are threatening." *See* SLOVENKO, *supra* note 178, at 315–16.

a broad advisory may imply that the therapist is withdrawing from helping the patient overcome conflicts leading to the dangerous situation.[229] And "what type of therapy would it be if destructive urges were not explored? Anger prompts a lot of people to enter therapy; good therapy gets people in touch with their anger."[230]

At the same time, there are suggested ways for psychotherapists to approach advising patients of the *Tarasoff* duty at the outset of treatment that can benefit the relationship. For example, one group of authors proposes "a new therapeutic alliance" for dealing with potentially dangerous patients, where both the psychotherapist and the patient come to a comprehensive initial agreement (before the treatment relationship is formed) about (1) therapeutic goals; (2) intensifying treatment when needed; (3) setting ground rules about alcohol, drug, or weapon use; (4) team-building conversations about the mutual commitment to prevent violent acts; and (5) clarifying options and procedures to follow if patient loses control).[231] Once this therapeutic alliance is formed, it is the psychotherapist's obligation to inform the patient fully regarding (1) limits of confidentiality; (2) the psychotherapist's *Tarasoff* duty; (3) the inherent problems with assessing risk; and (4) the psychotherapist's prior experience in dealing with other potentially dangerous patients (e.g., has the therapist ever had to follow through with a *Tarasoff* warning?).[232]

The content of an advisory may include the fact that the psychotherapist will not be able to hold the patient's threatening statements in confidence.[233] It may also include a more detailed description of the consequences of nonconfidential communication, such as the lack of privilege or, more specifically, lack of testimonial privilege in a subsequent legal proceeding. Each of these will be discussed in the remainder of Part I.B.3.b. The level of specificity of an advisory will likely have a varying effect upon the treatment relationship.[234]

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229. *See* GUTHEIL & APPELBAUM, *supra* note 74, at 195.

230. SLOVENKO, *supra* note 178, at 292.

231. BEDNAR ET AL., *supra* note 196, at 68–70.

232. *See id.*; *see also* Beck, *supra* note 207, at 199 (recognizing that discussing a *Tarasoff* warning with a patient can strengthen an alliance because it makes clear that the psychotherapist is committed to preventing violence and raises the consequences of what it would mean if the threat was carried out).

233. BEDNAR ET AL., *supra* note 196, at 68–70; *see also supra* note 215 and accompanying text.

234. A separate but highly relevant issue is how the content of an informed consent (in the form of an advisory about a *Tarasoff* duty) is necessarily shaped by the wide variance of *Tarasoff* laws across different states, as well as the psychotherapists' possible inaccurate knowledge of these laws. *See supra* notes 177–96 and accompanying text. These factors "raise [important] questions about the accuracy of informed consent regarding dangerousness," such as, "How can [psychotherapists] correctly inform clients about the limits of confidentiality if they themselves have incomplete understanding of those limits?" and, "Are [psychotherapists] telling clients that the law prevents them from honoring confidentiality when clients threaten others, when in fact, they often have options other than warning?" Pabian, Welfel & Beebe, *supra* note 184, at 12. The authors who pose these questions recommend significant changes to the current status of this profession's education

i. The Effect of an Advisory to Patients That a Psychotherapist Will Issue a *Tarasoff* Warning

This section will investigate the question, Once a patient is advised about a *Tarasoff* duty (and is, thus, made aware of the limits of confidentiality), how does this impact the patient's treatment? As soon as *Tarasoff* was decided, it was met with criticism by the mental health professional community.[235] One commentator predicted immediately that it "would lead to more danger by discouraging patients from seeking treatment and/or chilling patients' willingness to discuss issues of violence with their therapists."[236] The position is based on a "deterrence hypothesis," a belief that "some persons might avoid psychotherapy, and those within psychotherapy might be more guarded about what they would reveal."[237] Thus, without the assurance of confidentiality, "[r]eductions in the secrecy afforded to patients would harm the psychotherapeutic relationship."[238] The main support for the deterrence hypothesis draws from its facial validity and commonsense approach, as well as the anecdotal experiences of psychotherapists who see firsthand how confidentiality concerns may inhibit reluctant clients.[239]

There has not been extensive empirical support to give credence to the deterrence hypothesis.[240] Indeed, "[w]hile the absence of proof is not the proof of absence, this alleged lack of evidence surely does not help . . . [the] claim that [such a] qualified confidentiality policy will lead to bad outcomes."[241] The empirical data that does exist suggests that only "a small minority of clients and patients would be altogether deterred from

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and training regarding psychotherapists' *Tarasoff* duty. *See id.* at 11–12; *see also* Tolman, *supra* note 186, at 391–95 (presenting a training model for use with psychology students to provide basic legal knowledge of specific risk assessment and management strategies). *Contra* Fisher, *supra* note 203, at 6–7 & tbl.2 (cautioning against legally based training for psychologists and instead offering an ethical practice model that would allow for protection of a patient's confidentiality rights and include a plan for how to "respond ethically to legally imposed disclosure situations").

235. *See* Shuman & Foote, *supra* note 198 at 482 (discussing "the prophecies of doom for psychotherapy that surrounded the decision").

236. Buckner & Firestone, *supra* note 186, at 214 (citing Alan A. Stone, *The* Tarasoff *Decisions: Suing Psychotherapists To Safeguard Society*, 90 HARV. L. REV. 358 (1976)).

237. KNAPP & VANDECREEK, *supra* note 29, at 10.

238. *Id.*

239. *Id.* at 11–12; *see* Wise, *supra* note 214, at 184 (noting that psychotherapists "may . . . fear that any legal duty they have to divulge private communications may . . . harm the therapeutic relationship by disabusing patients of their comforting illusion of absolute confidentiality").

240. *See* IMWINKELRIED, *supra* note 27, § 5.2.2, at 295–96 (criticizing existing data as hardly conclusive); KNAPP & VANDECREEK, *supra* note 29, at 10; SHUMAN & WEINER, *supra* note 225, at 77 (criticizing support for the hypothesis as being "anecdotal rather than well designed empirical research"); Buckner & Firestone, *supra* note 186, at 214.

241. Christopher Robertson, *The Consequences of Qualified Confidentiality*, 6 AM. J. BIOETHICS 31, 31 (2006); *see* IMWINKELRIED, *supra* note 27, § 5.2.2, at 278.

consulting and that perhaps a significant minority would be dissuaded from being completely candid during the consultation."[242]

In reality, patients respond in a variety of ways when they are advised that their communication will not be kept confidential. One study looked at the effect on the therapeutic relationship when psychotherapists advised patients of the requirements of a *Tarasoff* duty and found that more than half of patients accepted the disclosure without anger or significant reaction.[243] Two of the twenty-three patients in the study were even thankful that the *Tarasoff* warning would be given.[244] About one-third of the patients became angry that the therapist had to issue the *Tarasoff* warning.[245] This study also asked psychiatric residents what they thought the impact of the patient knowing about the *Tarasoff* warning was upon the treatment relationship.[246] More than half of the therapists felt that there was no apparent effect (within fifteen of twenty-seven cases).[247] In only five cases, a negative impact was noted and in three cases a positive effect was even noted.[248] Therefore, studies "suggest that therapy is not hindered" when confidentiality is breached due to a *Tarasoff*-required warning, "so long as a patient is involved in the decision and/or appropriately informed."[249]

This has led commentators to note that "the earlier anticipated negative effects [from recognizing a legally required *Tarasoff* duty] have not materialized," because "[t]here is just no evidence thus far that patients have been discouraged from coming to therapy, or discouraged from speaking freely once there, for fear that their confidentiality will be

242. IMWINKELRIED, *supra* note 27, § 5.2.2, at 295. In a survey study, California psychotherapists who were asked, "Once a patient is aware that you might have to discuss his case with someone else, . . . have you *noticed* any reluctance in patients thus told to discuss their own violent tendencies?" 47.5% of the surveyed psychotherapists had not noticed any reluctance, while only 24.5% said they had, and 27.9% did not respond. Wise, *supra* note 214, at 177 & n.67. Despite what these surveyed psychotherapists may have observed about their patients, a "large majority of the therapists [still] apparently believe[d] that patients feel inhibited if they know that their therapists might not maintain strict confidentiality." *Id.* at 176 & n.63 (79.1% of surveyed psychotherapists responded affirmatively to the following question: "Once a patient is aware that you might have to discuss his case with someone else, do you think that the patient is less likely to divulge certain information to the therapist?"). The Wise study seems to illustrate the disconnect between what the psychotherapists anticipate (the deterrence hypothesis) and what they actually observe (lack of support for the deterrence hypothesis).

243. Binder & McNiel, *supra* note 215, at 1212–14 (thirteen of the twenty-three patients).

244. *Id.* at 1214 (One patient reportedly said, "Now he will stop harassing me," while the other said, "It's good that you will be scaring my landlord.").

245. *Id.* (eight of the twenty-three patients).

246. *Id.*

247. *Id.*

248. *Id.*

249. Buckner & Firestone, *supra* note 186, at 220 (citing Beck, *supra* note 207; Beck, *supra* note 214; Binder & McNiel, *supra* note 215; McNiel, Binder & Fulton, *supra* note 193).

breached."[250] Generally, patients seem to accept that there are limits of confidentiality in psychotherapy when they are informed of a *Tarasoff* duty.[251] Although it may be problematic that many of these studies are dependent on questions posed to small groups of patients or psychotherapists who may be reluctant to describe ineffectiveness in their own therapy,[252] empirical results still suggest that "absolute confidentiality is not a prerequisite for a trusting therapy relationship, so long as the limits of confidentiality are discussed with the patient."[253]

ii. The Effect of an Advisory to Patients About the Status of Privilege

Failure of proof that a *Tarasoff* duty has a detrimental effect upon the treatment relationship prompted the Supreme Court of California to revisit the issue after its first decision in 1974.[254] In 1976, the court stated that

> it does not appear that our decision in fact adversely affected the practice of psychotherapy in California. Counsel's forecast of harm in the present case strikes us as equally dubious.
>
> We note, moreover, that [California] Evidence Code section 1024, enacted in 1965, established that psychotherapeutic communication is not privileged when disclosure is necessary to prevent threatened danger. We cannot accept without question counsels' implicit assumption that effective therapy for potentially violent patients depends upon either the patient's lack of awareness that a therapist can disclose confidential communications to avert impending danger, or upon the therapist's advance promise never to reveal nonprivileged threats of violence.[255]

The State of California is unique in that it explicitly carved out a "dangerous patient" exception to its state psychotherapist-patient privilege by allowing a psychotherapist to testify whenever a *Tarasoff* warning was necessary to avert harm.[256] In keeping with this rationale, the court ruled, "The protective privilege ends where the public peril begins."[257]

Even in jurisdictions where there is no recognized dangerous-patient exception to privilege, the patient's knowledge about the limits of confidentiality has a direct bearing on the psychotherapist-patient

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250. *Id.* at 221 ("Earlier concerns about disruption of treatment have been overblown."); *see* Shuman & Foote, *supra* note 198, at 482 ("Most patients and prospective patients are not dissuaded from seeking therapy by the risk of a judicially compelled breach of confidentiality.").

251. Buckner & Firestone, *supra* note 186, at 222.

252. *See id.* at 221.

253. *Id.* at 222.

254. Tarasoff v. Regents of the Univ. of Cal., 529 P.2d 553 (Cal. 1974), *vacated*, 551 P.2d 334 (Cal. 1976).

255. *Tarasoff*, 551 P.2d at 346 n.12.

256. *Id.* at 347. *See generally* Robert Weinstock, Gregory B. Leong & J. Arturo Silva, *Potential Erosion of Psychotherapist-Patient Privilege Beyond California: Dangers of 'Criminalizing'* Tarasoff 19 BEHAV. SCI. & L. 437, 441–44 (2001) (criticizing California common law for extending the dangerous-patient exception to criminal proceedings).

257. *Tarasoff*, 551 P.2d at 347.

testimonial privilege.[258] Indeed, the Supreme Court noted in *Jaffee* that, given the importance of the patient's understanding that his communications would not be publicly disclosed, any promise of confidentiality afforded by a privilege "would have little value if the patient were aware that the privilege would not be honored in a federal court."[259] A meaningful privilege doctrine requires that the patient knows his communication is confidential.[260] The *Jaffee* decision highlighted this: "At the outset of their relationship, the ethical therapist must disclose to the patient 'the relevant limits on confidentiality.'"[261] Thus, the decision "added a new layer of complexity to the obligations of clinicians to address the confidentiality of therapist-patient communications."[262] The extent to which the psychotherapist must also warn the patient about how the limited confidentiality could affect privilege remains unsettled today.

A psychotherapist's questions—whether to advise his patients about his *Tarasoff* duty, when to provide such an advisory, and, now, whether to elaborate on the consequences for a patient's claim of privilege—pose a "clinicolegal" dilemma,[263] because of their potential detrimental effects on successful mental health treatment. An advisory to the patient about the limits of confidentiality "begs the question of whether the patient really understands that a disclosure (by the therapist of such threats) for one purpose (preventive) is a disclosure for all other purposes, including punitive."[264] Extending this logic further, "a rule that patients automatically waive . . . privilege by accepting a psychotherapist's initial confidentiality disclosure effectively means patients will forfeit their privilege anytime they seek therapy."[265]

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258. *See supra* Part I.A.4.a.

259. Jaffee v. Redmond, 518 U.S. 1, 13 (1996).

260. *See supra* notes 78–82 and accompanying text.

261. *Jaffee*, 518 U.S. at 13 n.12 (citing AM. COUNSELING ASS'N, CODE OF ETHICS AND STANDARDS OF PRACTICE A.3.a (1995); AM. PSYCHOLOGICAL ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT Standard 5.01 (1992); NAT'L FED'N OF SOC'YS FOR CLINICAL SOC. WORK, CODE OF ETHICS V(a) (1988)).

262. Shuman & Foote, *supra* note 198, at 483.

263. *See* Leong, Silva & Weinstock, *supra* note 220, at 304; *see also* Susan Parke & Chandrika Shankar, *Repeated Threats in Therapy*, 37 J. AM. ACAD. PSYCHIATRY & L. 115, 117 (2009) (*Tarasoff* disclosures may be necessary to protect other's safety, but "ethics-related dilemmas and questions arise when that disclosure might be used as a prosecutorial tool."); Weinstock, Leong & Silva, *supra* note 256, at 447 (referring to an "ethical problem").

264. Sameer P. Sarkar, *Commentary: No Place To Hide*, 32 J. AM. ACAD. PSYCHIATRY & L. 96, 97 (2004); *see id.* at 96 (posing further questions such as the following: "Why else would a patient reveal violent fantasies if not to seek help and ask the therapist to stop him from acting on those fantasies? Doesn't he know that a secret out for one purpose is a secret out for all purposes? But does a patient really know?"); *see also* Parke & Shankar, *supra* note 263, at 117 (asking, after the decision of *United States v. Auster*, "How do we ascertain whether patients are well informed as to the limits of confidentiality?").

265. Brian P. McKeever, *Contours and Chaos: A Proposal for Courts To Apply the "Dangerous Patient" Exception to the Psychotherapist-Patient Privilege*, 34 N.M. L. REV. 109, 144 (2004).

And yet people generally are not aware of the existence or nonexistence of the privileges, and therefore their candor in the relationship is likely not influenced by the existence of a privilege.[266] Studies indicate that, in practice, professional psychotherapists "often advise their . . . patients at the commencement of the relationship regarding the existence (or nonexistence) of a privilege."[267] If this is true, as the studies suggest, this may also indicate why frequent patients are more likely than members of the general public to be aware of the psychotherapist-patient privilege.[268]

Psychotherapists who are concerned about the patient's awareness of privilege may choose to fully disclose and obtain informed consent from a patient along the lines of *Miranda v. Arizona*,[269] whenever a *Tarasoff* warning is necessary.[270] Such advice would protect an "unwary patient from dangerous self-disclosure,"[271] which is especially prudent if a

266. MUELLER & KIRKPATRICK, *supra* note 13, § 5.1, at 330. One recent case in Connecticut has dealt with the dilemma by suggesting advisories to patients to ensure they know at least the limit of confidentiality, because citizens are presumed to know the law. State v. Orr, 969 A.2d 750, 774 n.10 (Conn. 2009) (Palmer, J., concurring). The concurring opinion in *Orr* states that "clients of social workers are presumed to know that, under § 52-136q(c)(2) [Connecticut's *Tarasoff*-model law regarding a social worker's duty to warn], a social worker is authorized to disclose certain threats against third parties and, therefore, that those threats are not made in confidence." *Id.* Therefore, a patient is put "on notice" that if he communicates threats to a social worker that fall within the scope of the statute, those threats potentially may be disclosed and are not confidential, because in common law "'everyone is presumed to know the law.'" *Id.* (quoting State v. Knybel, 916 A.2d 816, 821 (Conn. 2007)).

267. MUELLER & KIRKPATRICK, *supra* note 13, § 5.1, at 331 (citing Shuman & Weiner, *supra* note 77).

268. *Id.*; *See* SHUMAN & WEINER, *supra* note 225, at 111 (survey study of laypeople showed sixty-four percent of respondents "said they did not know," and only twenty percent "actually knew, or guessed correctly, [as to] the status of privilege."). *But see* Shuman & Foote, *supra* note 198, at 483 (recognizing that even in *Jaffee*, where Officer Redmond herself proceeded with six months of employer-mandated counseling without ever being informed or asking to know that Illinois had not yet adopted a federal psychotherapist-patient privilege, the officer's behavior seems to contradict "the claim that people, particularly those who are legally sophisticated, will not enter into therapy unless there is an assurance of confidentiality protected by a privilege").

269. 384 U.S. 436 (1966).

270. Fleming & Maximov, *supra* note 220, at 1059–60 (citing *Miranda*, 384 U.S. 436); *see* SLOVENKO, *supra* note 178, at 291 (noting that "many urge the therapist to obtain an informed consent at the outset of therapy" and "[a]lthough not legally required, many therapists nowadays [do in fact] give a '*Miranda*'-type warning"); Leong, Silva & Weinstock, *supra* note 220, at 294–95 (observing that "many psychotherapists in both the public and private sectors have operationalized the use of *Miranda*-like warnings in the mental health (civil) system" and "[a]lthough no exact figures are available, many psychotherapists issue written and/or oral warnings to their patients prior to the onset of evaluation and/or treatment," which consist of an advisory about the "potential legal consequences of revealing certain information that may lead to . . . activation of the *Tarasoff*. . . duty").

271. SLOVENKO, *supra* note 178, at 291; *see* Fleming & Maximov, *supra* note 220, at 1060 ("Often patients . . . assume a security which is in reality unavailable. An overriding concern, therefore, is the protection of these unwary patients from self-threatening disclosures.").

patient's threat of violence could lead to punitive incarceration.[272] "In essence, such warnings give the patient the inference that if certain information is not withheld, that is, the patient does not remain 'silent,' deleterious legal consequences can arise for the patient."[273] This is a revisit to the deterrence hypothesis, but now the chilling effect results from the patient's knowledge that he does not have a privilege to assert in a court proceeding that could involve punitive consequences.[274]

Jaffee's basis for creating a federal psychotherapist privilege was the Court's "assumption that without the assurance of an evidentiary privilege, the typical patient would be unwilling to make the sorts of disclosures that are essential in effective psychotherapy."[275] And it certainly makes sense that "the extent to which patients are informed about the law and the extent to which the law is consequential for them are two of the factors that determine whether limitations to privacy will affect patients' self-disclosures."[276] In fact, results of a study about privilege done by the *Yale Law Journal* in 1962 support this assumption: seventy-one percent of the people surveyed "reported that they would be less likely to disclose themselves fully to a counselor without protection of their communication."[277] In a more recent study, members of the public in Washington DC were surveyed about how willing they thought a hypothetical patient would be to tell his therapist about thoughts and feelings about physical abuse if the patient knew the information would be privileged versus if the patient knew the information would not be privileged (because the therapist would be questioned about the information

272. Leong, Silva & Weinstock, *supra* note 220, at 301.

273. *Id.* at 293, 301 (leading these authors to caution that "[p]sychotherapists have an ethical responsibility to avoid becoming undercover police detectives who disguise themselves as clinicians in a dishonest way").

274. *See* Shuman & Foote, *supra* note 198, at 481–82; *see also* KNAPP & VANDECREEK, *supra* note 29, at 154; SIMON, *supra* note 140, at 204 ("Patients already frightened of their own aggression may find such a warning confirmatory of their worst fears. Secretive patients may seize upon such a warning to withhold verbal expression of violent feelings."); Leong, Silva & Weinstock, *supra* note 220, at 300; Weinstock, Leong & Silva, *supra* note 256 at 447 (proposing that it "is likely that the effect on therapy would be quite chilling . . . if . . . patients were warned that if they tell the therapist that they want help not to severely hurt someone but they later killed that person, the therapist at a subsequent trial could be called to testify for the sole purposes of using the patient's prior concern to prove premeditation and again at the penalty phase to obtain a death penalty").

275. IMWINKELRIED, *supra* note 27, § 5.2.2, at 280; Harris, *supra* note 166, at 54 (The *Jaffee* Court "assumed that a patient who knows or ethically must be informed that the therapist may later be compelled to testify to an expression of violent intent will be much less likely to vent such intent and allow for therapeutic intervention to prevent the threatened behavior.").

276. Daniel O. Taube & Amiram Elwork, *Researching the Effects of Confidentiality Law on Patients' Self-Disclosures*, 21 PROF. PSYCHOL.: RES. & PRAC. 72, 74 (1990).

277. SHUMAN & WEINER, *supra* note 225, at 79 (citing Comment, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privilege Communication Doctrine*, 71 YALE L.J. 1226 (1962)).

in a legal proceeding).[278] The respondents who were told that the patient's communication would be privileged "had significantly higher willingness-to-disclose scores" than the respondents who were told there was no privilege.[279]

And yet, many other empirical studies are "at odds with the hypothesis that in the typical case, the lack of an evidentiary privilege deters a person from either consulting a third party such as a psychotherapist or making necessary disclosures to the consultant."[280] In fact, "[i]t seems very unlikely that privilege or lack of privilege deters [patients] from seeking . . . treatment."[281]

Research also reveals that most people do not rely on the existence of privilege to decide whether to make disclosures in therapy or whether to trust their therapist.[282] For example, a study conducted by law professor Daniel Shuman and psychiatrist Myron Weiner showed most lay people "would be significantly less disclosing to a therapist if there were no privilege," and yet, "[t]his was not so great a concern that many lay persons were aware of the status of privilege in their state or province."[283] In fact, Shuman and Weiner concluded that "there is little relationship between patients withholding information from their therapist and the status of privilege," based on research that forty-one percent of surveyed patients in psychoanalysis treatment withheld information from their therapist but "seemed to do so for reasons unrelated to fear of public disclosure."[284] Shuman and Weiner ultimately concluded that "the norm was not so much one of disclosure versus nondisclosure, but disclosure in the service of the patient versus disclosure that might harm the patient's self-esteem or self-

278. *See* Jennifer Evans Marsh, *Empirical Support for the United States Supreme Court's Protection of the Psychotherapist-Patient Privilege*, 13 ETHICS & BEHAV. 385, 387–89 (2003).

279. *Id.* at 391–93; *see also* Jennifer Evans Marsh, *Correction to "Empirical Support for the United States Supreme Court's Protection of the Psychotherapist-Patient Privilege,"* 14 ETHICS & BEHAV. 197, 199 (2004) (affirming this result).

280. IMWINKELRIED, *supra* note 27, § 5.2.2, at 278 (citing 24 CHARLES ALAN WRIGHT & KENNETH W. GRAHAM, FEDERAL PRACTICE AND PROCEDURE, § 5472, at 84 (1986); Raymond F. Miller, Comment, *Creating Evidentiary Privileges: An Argument for the Judicial Approach*, 31 CONN. L. REV. 771, 783 (1999)); *see* APPELBAUM, *supra* note 177, at 89, 109 n.98; *cf.* Fred C. Zacharias, *Rethinking Confidentiality*, 74 IOWA L. REV. 351, 386 (1989) (study in which only 15.1% surveyed said that they would withhold information if the lawyer "promised confidentiality except for specific types of information which he/she described in advance").

281. *See* SHUMAN & WEINER, *supra* note 225, at 111 (relying on evidence that when the Texas state privilege statute was passed, there was no increase in therapy patients, according to their Texas survey, and also citing evidence that both the public and patients in therapy are "relatively unaware of the status of privilege"). Also, in Shuman and Weiner's patient survey study, only six percent would have sought therapy earlier if they had known there was a privilege, but it was unclear if this sample included persons prone to violence, since such an inquiry was not made. *Id.*

282. *Id.* at 136.

283. *Id.* at 110–11.

284. *Id.* at 112 ("No relationship was found between the legal status of privilege and patients' disclosure in therapy . . . .").

interest."[285] "[E]mpirical studies suggest that while confidentiality is important in therapeutic relationships, privilege is not."[286] This can be explained by the fact that "[p]sychotherapists, as competent professionals or as caring friends, are expected to exercise discretion in what they reveal."[287] As a consequence, "[p]atients reacted positively when therapists made disclosures that helped them regain control of themselves or helped to protect others," but "[w]hen information that was experienced as embarrassing or personally damaging was revealed, no matter what the reason, the therapeutic relationship was endangered and the persons who trusted in them were often harmed psychologically."[288]

Another study showed that "patients who remain in therapy even after being advised of the limits on confidentiality [and loss of privilege] typically do so because they recognize their need for help and . . . that psychotherapy may provide it."[289] However, it should be noted that in the aforementioned study, patients were advised as to the loss of privilege in the context of civil involuntary commitment hearings, rather than criminal proceedings.[290] It is believed that after involuntary hospitalization, the psychotherapist-patient relationship can continue during and after the patient's hospitalization without deleterious effect.[291]

Although these studies seem to belie the "theory's essential premise that the average client or patient would refuse to either consult or withhold necessary information from the consultant,"[292] some of the studies suffer from weaknesses, "including a failure to distinguish between patient reactions to out-of-court disclosure and patient reactions to judicially compelled disclosure."[293] Furthermore, the nature of the research is difficult to translate into truly normative observations. Generally, the

285. *Id.* at 111.
286. *Id.* at 113.
287. *Id.*
288. *Id.*
289. Comment, *Evidence*, *supra* note 203, at 2200 & n.42 (citing Robert D. Miller, Gary J. Maier & Michael Kaye, Miranda *Comes to the Hospital: The Right To Remain Silent in Civil Commitment*, 142 AM. J. PSYCHIATRY 1074, 1076 (1985)) ("study in which . . . psychotherapist[s] informed patients that anything they said during therapy sessions could be used against them in an involuntary civil commitment hearing and . . . the majority of the patients still engaged in open disclosure with the therapist, largely because of their perceived need for help and their belief that talking to the staff was necessary to obtain it").
290. *See id.*
291. This logic is displayed in *United States v. Hayes*, 227 F.3d 578, 585 (6th Cir. 2000) ("While that patient, by definition, will initially reject the prospect of hospitalization, it may ultimately improve his mental state and should not leave a stigma after the stay concludes."). *But see* McKeever, *supra* note 265, at 134–35 (asserting that there is "[n]o reason . . . to believe that a psychotherapist's testimony at a civil [involuntary commitment] hearing will have a less damaging effect on the therapeutic process than the same testimony at a criminal hearing" since "both carry the same potential to destroy the atmosphere of confidence and trust underlying the [psychotherapist] privilege" (citing Lawson R. Wulsin, Harold Bursztajn & Thomas G. Gutheil, *Unexpected Clinical Features of the* Tarasoff *Decision: The Therapeutic Alliance and the "Duty To Warn,"* 140 AM. J. PSYCHIATRY 601, 602 (1983))).
292. IMWINKELRIED, *supra* note 27, § 5.2.2, at 296.
293. *Id.* § 5.2.2, at 295.

studies that have been done inquire into what did or would have motivated people to engage in certain types of conduct, and "'[s]ocial psychology studies indicate that people are often unable to say what really motivated them. Thus, empirical survey studies relying on self-reporting about whether the existence of a privilege affected the privilege-holders' behavior are inherently indeterminate.'"[294]

Regardless of whether an advisory to a patient about a psychotherapist's *Tarasoff* warning includes information about the status of privilege, psychotherapists now may recognize that, at least in some jurisdictions, there is a real possibility that they could be called to disclose or testify regarding threats a patient communicates to them.[295] This risk "may prompt the patient and therapist to deal with privilege issues in a proactive manner."[296] Shuman and another law professor, William Foote, recommend that when psychotherapists anticipate there is a moderate risk of compelled disclosure and "if the patient has not already engaged in behavior that effectively waived privilege," then the psychotherapist should consider bolstering the patient's privilege claim by (1) obtaining "a written informed consent that includes a statement of the patient's expectation that the therapist will keep therapeutic communications confidential," (2) having the patient take steps to minimize disclosures that would weaken the privilege claim, and (3) receiving "clear instructions from the patient about how to react to demands for disclosure."[297] Of course, informed consent may not even be required if a *Tarasoff* warning is mandatory,[298] but documenting the patient's wishes and intent about confidentiality could bolster the patient's privilege claim later on.[299] Shuman and Foote also recommend that when a disclosure of patient information "is inevitable, the patient and therapist may wish to limit the range of issues discussed in the course of psychotherapy," although this "may not be the optimal therapeutic strategy."[300]

II. CIRCUIT SPLIT: IS A DANGEROUS PATIENT'S THREAT PRIVILEGED IF THE PATIENT WAS ADVISED OF THE PSYCHOTHERAPIST'S *TARASOFF* DUTY?

Part II reviews the circuit split regarding whether a patient's threat that is communicated to his psychotherapist after the patient is advised of the *Tarasoff* duty is privileged. This part addresses this split in three sections. Part II.A looks at decisions that find an exception to privilege and would allow a psychotherapist to testify about a patient's threats, regardless of

294. *Id.* (quoting Deana A. Pollard, *Unconscious Bias and Self-Critical Analysis: The Case for a Qualified Evidentiary Equal Employment Opportunity Privilege*, 74 WASH. L. REV. 913, 999 (1999)).

295. *See infra* Part II.A, II.C.

296. Shuman & Foote, *supra* note 198, at 485.

297. *Id.*

298. *See supra* notes 210, 212 and accompanying text.

299. Shuman & Foote, *supra* note 198, at 485.

300. *Id.*

whether there was an advisory to the patient about the duty to warn. These opinions find that there should be a dangerous-patient exception to privilege, but only when the patient's threat was so serious that providing a *Tarasoff* warning was the only way to avert harm. Thus, the *Tarasoff* warning itself creates the dangerous-patient exception and a psychotherapist would not be barred from testimony if such a warning was required. This is the position of the Tenth Circuit in *United States v. Glass*,[301] with which the concurring opinion in *United States v. Chase*[302] also agreed, reviewed in Part II.A.1 and Part II.A.2, respectively. Part II.A.3 discusses recent cases that have applied the dangerous-patient exception to federal psychotherapist-patient privilege.

In contrast, the Sixth and Ninth Circuits hold that there is no dangerous-patient exception to the testimonial privilege. These courts reason that testimonial privilege is maintained, even after an advisory is provided to a patient about a *Tarasoff* duty. Part II.B.1 examines the decision of the Sixth Circuit in *United States v. Hayes*[303] and Part II.B.2 reviews the majority opinion of the Ninth Circuit in *Chase*.

Lastly, Part II.C describes the position that there can be no privilege if a patient communicates a threat after receiving an advisory about the psychotherapist's *Tarasoff* duty. Part II.C.1.a discusses the dissenting opinion of Judge Danny J. Boggs in *Hayes* and Part II.C.1.b returns to the concurring opinion led by Judge Andrew J. Kleinfeld in *Chase*. Finally, Part II.C.2 addresses the unanimous decision of the Fifth Circuit in *United States v. Auster*,[304] as well as opposing arguments raised in the recent petition for certiorari to the Supreme Court.[305] These federal circuit decisions have effectively resulted in a 1-2-1 split as to the status of federal psychotherapist-patient testimonial privilege for a dangerous patient's threats delivered after the psychotherapist advises him of a *Tarasoff* duty.[306]

A. *Circuit Opinions: Dangerous-Patient Exception Allows a Psychotherapist's Testimony, Regardless of Advising the Patient of the* Tarasoff *Duty*

Some opinions have held that a patient's communication is not privileged when a psychotherapist was required to issue a *Tarasoff* warning to a third party. They find that a dangerous-patient exception to the testimonial privilege exists when the threat was serious, it was uttered by the patient,

301. 133 F.3d 1356 (10th Cir. 1998).
302. 340 F.3d 978 (9th Cir. 2003) (en banc) (Kleinfeld, J., concurring).
303. 227 F.3d 578 (6th Cir. 2000).
304. 517 F.3d 312 (5th Cir.), *cert. denied*, 129 S. Ct. 75 (2008).
305. *See* Brief for the National Association of Social Workers and the Louisiana Chapter of the National Association of Social Workers as Amici Curiae in Support of Petitioners, Auster v. United States, 129 S. Ct. 75 (2008) (No. 07-10877), 2008 WL 2435917.
306. *See* Posting of Robert Loblaw to Federal Judiciary: Decisions of the Day, http://blogs.enotes.com/decision-blog/2008-02/fifth-widens-circuit-split-over-psychotherapist-patient-privilege/ (Feb. 11, 2008, 19:27 PST) (on file with author).

and the psychotherapist's disclosure was the only way to avert harm.[307] These opinions rely on the literal language found in footnote nineteen in the *Jaffee v. Redmond* decision, which states,

> "Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist."[308]

1. Tenth Circuit: *United States v. Glass*

The Tenth Circuit determined that there should be a dangerous-patient exception to privilege, drawing support from the literal wording of the *Jaffee* footnote, that the "threat was serious when it was uttered and . . . its disclosure was the only means of averting harm . . . when the disclosure was made."[309]

In *Glass*, a patient was voluntarily admitted to the hospital for his ongoing mental illness.[310] During his visit, Archie Monroe Glass told his psychotherapist that he wanted to get into the history books by shooting Bill and Hillary Clinton.[311] Glass was later released to his father's home and agreed to participate in an outpatient mental health program.[312] Ten days later, when an outpatient nurse discovered Glass had left his father's home and could not be located, she contacted law enforcement to warn about the patient's threatening statements.[313] Glass was indicted for knowingly and willfully threatening to kill the President of the United States, in violation of federal law.[314]

There was no dispute that the statement was made to a psychotherapist during a confidential treatment session.[315] The court determined that there could be an exception to the testimonial privilege if it could be proven that the threat was serious at the time the patient uttered it and if the *Tarasoff*-required warning made by the psychotherapist was the only way to avert harm to the third party at risk.[316] In *Glass*, the disclosure to law enforcement took place ten days after the threat was uttered; accordingly, the court determined that the facts of the case were "hardly an indication of

307. *See* Harris, *supra* note 166, at 34.
308. United States v. Glass, 133 F.3d 1356, 1357 (10th Cir. 1998) (quoting Jaffee v. Redmond, 518 U.S. 1, 18 n.19 (1996)).
309. *Id.* at 1360.
310. *Id.* at 1357.
311. *Id.*
312. *Id.*
313. *Id.*
314. *Id.*; *see* 18 U.S.C. § 871(a) (2006).
315. *Glass*, 133 F.3d at 1359.
316. *See id.* at 1360; *see also* United States v. Chase, 340 F.3d 978, 994 (9th Cir. 2003) (en banc) (Kleinfeld, J., concurring) (citing *Glass*, 133 F.3d at 1360).

a threat which can only be averted by means of disclosure."[317] It remanded the case to the district court to determine the seriousness of the threat when uttered and whether disclosure of the records was the only means of averting harm.[318] "In essence, the court accepted the existence of a 'dangerous patient' exception to the psychotherapist-patient privilege on the basis of footnote 19 in *Jaffee*."[319]

2. Ninth Circuit: *United States v. Chase* (Concurring Opinion)

The same concerns were echoed several years later by the Ninth Circuit in the concurring opinion of *United States v. Chase*.[320] In *Chase*, a patient was arrested and charged with making threats to murder federal law enforcement officers.[321] Steven Gene Chase made these threats to his psychiatrist even after receiving several advisories that the psychiatrist would be required to give a *Tarasoff* warning to third parties.[322] The U.S. District Court for the District of Oregon allowed the psychiatrist to testify at trial, and the defendant was convicted.[323] On appeal, the majority opinion of the Ninth Circuit stated that the district court erred by allowing the psychiatrist to testify about privileged communication, but affirmed the conviction because the error was harmless.[324] The concurring opinion agreed with the result and affirmed the conviction.[325] However, the concurring opinion dissented from the majority's view that the patient's communication in this case was actually privileged.[326] The concurring opinion argued that there should be no privilege when a patient makes an "imminent, seriously intended, and properly disclosed threat to commit murder."[327]

Like the *Glass* holding, the concurring opinion in *Chase* relied on the "plain English" of the *Jaffee* footnote.[328] It stated that "[t]here is just no getting around the proposition that *Jaffee* said, and meant, that the psychotherapist-patient 'privilege must give way,' referring to the privilege

317. *Glass*, 133 F.3d at 1359 (There was no basis to discern how ten days after communicating with a psychotherapist the threatening statement was somehow "transformed into a serious threat of a harm which could only be averted by disclosure.").

318. *Id.* at 1360.

319. Robert H. Aronson, *The Mental Health Provider Privilege in the Wake of* Jaffe v. Redmond, 54 OKLA. L. REV. 591, 604 (2001) (citing Nelken, *supra* note 79, at 33–38).

320. 340 F.3d 978, 993 (Kleinfeld, J., concurring). The facts of this case are introduced in Part III.B.2. *See infra* notes 407–17 and accompanying text.

321. *Chase*, 340 F.3d at 981.

322. *See infra* notes 412–17 and accompanying text.

323. *Chase*, 340 F.3d at 979.

324. *Id.*

325. *Id.* at 993 (Kleinfeld, J., concurring).

326. *Id.*

327. *Id.*

328. *See id.* at 995 ("The Supreme Court has spoken expressly to the issue in this case, saying that the privilege does not apply in cases such as the one before us . . . . The case before us is precisely the one described in the *Jaffee* footnote. The Supreme Court has said in the plainest English that in cases such as the one before us, 'the privilege must give way.'"(quoting Jaffee v. Redmond, 518 U.S. 1, 18 n.19 (1996)).

under Rule 501 to refuse to testify."[329] The footnote could only be referring to the privilege not to testify in federal court or, stated another way, the patient's privilege to bar the psychotherapist's testimony in court.[330]

The concurring opinion in *Chase* stated that the only way to read footnote nineteen is that privilege "does not exist 'if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.'"[331] A *Tarasoff* warning is justified when "[t]he patient [is] understood by his psychotherapist to be past the point of seeking help that would prevent criminal action, [and] it [is] essential to warn . . . prospective victims . . . ."[332] Judge Kleinfeld stated that this case was not about a patient asking for help by saying, "'I have homicidal thoughts and feelings, and although I am not going to act on them, they disturb me and I need your help to get rid of them.'"[333]

The concurring opinion in *Chase* stressed that recognition of a dangerous-patient exception was legitimate, despite the language being tucked away in a footnote. It stated that although the *Jaffee* footnote is dicta, it should be given even more weight since courts are supposed to interpret whether there is privilege "in the light of reason and experience."[334] Thus, it should be interpreted literally—and not read merely as recognizing an exception to confidentiality[335] or as recognizing an exception to testimonial privilege—but limited to the context of involuntary commitment proceedings.[336]

A common argument against recognition of a dangerous-patient exception is that there is no reason to deny privilege to the communication by the time of trial, when the danger has been quelled.[337] However, it also may be unjustified to assume that the threat to a potential victim has passed by the time of trial.[338] Furthermore, a criminal trial may be the most

329. *Id.* at 996 (quoting *Jaffee*, 518 U.S. at 18 n.19).

330. *Id.* at 995. Opponents prefer to interpret the *Jaffee* footnote language as a reference to situations where psychotherapists need to testify during involuntary commitment hearings. However, there is no federal commitment law, and, in fact, commitment procedure is governed by state law and takes place in state courts, where federal evidentiary rules do not apply. Appelbaum, *supra* note 151, at 715 (citing Comment, *Evidence—Federal Testimonial Privilege—Ninth Circuit Holds That There Is No Dangerous-Person Exception to the Federal Psychotherapist-Patient Privilege.*—United States v. Chase, *340 F.3d 978 (9th Cir. 2003) (en banc)*, 117 HARV. L. REV. 996 (2004)).

331. *Chase*, 340 F.3d at 995 (Kleinfeld, J., concurring) (quoting Jaffee v. Redmond, 518 U.S. at 18 n.19).

332. *Id.* at 993.

333. *Id.*

334. *Id.* at 995.

335. There is some belief that the footnote could be referring to the privilege to have communication kept in confidence. *See id.* at 982 (majority opinion) ("A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purposes of diagnosis or treatment . . . ."). However, the word choice in the footnote is "privilege," and "[a]ny lawyer knows what the word 'privilege' means," according to the concurring opinion. *Id.* at 995 (Kleinfeld, J., concurring).

336. *Id.* at 985 & n.3 (majority opinion).

337. *See infra* notes 422–23 and accompanying text.

338. *See* Appelbaum, *supra* note 151, at 715.

effective and fastest way to protect the public: police do not provide bodyguard services, and state civil commitment proceedings are bureaucratic and may not be fast enough to prevent a threat.[339] It is also "possible [for a person] to execute threats even after criminal proceedings have begun, especially when a judgment for the prosecution is impossible without the necessary evidence."[340]

Indeed, the psychotherapist's testimony can have high evidentiary value, and there exists a common-law preference for truth over privilege.[341] Where a threat of imminent harm is understood by a psychotherapist to be so serious as to require disclosure, the social interest in assuring that the judge and jury know the whole truth greatly exceeds the value of preserving any remaining shreds of the confidential relationship.[342] The concurring opinion in *Chase* declared, "The cat being already out of the bag, trial is no occasion for stuffing it back in."[343]

Lastly, the opinion addressed the possibility that a patient will stop therapy once he finds out that his psychotherapist will testify against him in a criminal trial. It proposed that any detrimental impact on the therapeutic treatment relationship "will doubtless already have occurred where the psychotherapist betrayed their confidences to their worst enemies" as required by a state's *Tarasoff* warning law.[344]

The recognition of a dangerous-patient exception, as illustrated in the holding of *Glass* and the concurring opinion of *Chase*, is unrelated to the patient's knowledge about whether his statement to the psychotherapist was confidential.[345] The opinions assert that privilege gives way when two conditions are met: the threat was serious when uttered and disclosure was the only way to avert harm to a third party.[346] When these two conditions are met, there is an exception to privilege.

3. Application of the Dangerous-Patient Exception to Privilege in Case Law

In a recent unreported case in the U.S. District Court for the Southern District of Florida, *United States v. Highsmith*,[347] the court recognized the

339. *Chase*, 340 F.3d at 997 (Kleinfeld, J., concurring); *see* Huston Combs, Note, *Dangerous Patients: An Exception to the Federal Psychotherapist-Patient Privilege*, 91 KY. L.J. 457, 473–74 (2003) (arguing that language in the footnote that states that the privilege gives way if it is "necessary to avert harm" means that all other possible alternatives to avoid harm have been exhausted and, in rare instances, a criminal proceeding may actually be the only way to avert harm); *see also* McKeever, *supra* note 265, at 130–36.

340. Combs, *supra* note 339, at 475.

341. *Chase*, 340 F.3d at 998.

342. *Id.* at 998.

343. *Id.*

344. *Id.* at 997.

345. *See* United States v. Auster, 517 F.3d 312, 317 (5th Cir.), *cert. denied*, 129 S. Ct. 75 (2008).

346. *See Chase*, 340 F.3d at 994 (citing United States v. Glass, 133 F.3d 1356, 1360 (10th Cir. 1998)).

347. No. 07-80093-CR, 2007 WL 2406990 (S.D. Fla. Aug. 20, 2007).

existence of a dangerous-patient exception so that "a psychotherapist may testify about confidential communications received from a patient 'if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.'"[348] Applying this standard from *Glass*, the court determined that the threat did not have a serious risk of realization.[349]

The facts of this case mirror the facts in *Glass* closely. The defendant voluntarily sought admission to a hospital because of homicidal and suicidal intentions and specifically expressed a plan to shoot an administrative law judge who had ruled against him in a Social Security proceeding.[350] While in the hospital, defendant repeated his threats and indicated he had a gun at home that he planned to use.[351] The hospital staff psychotherapist determined that the threat was viable "[b]ased upon the repeated nature of the threats, the specific identity of the potential victim, [d]efendant's claim of possession of a gun and his refusal to allow the doctor to verify the existence of the gun [since he would not consent to the doctor asking his wife]."[352]

The psychotherapist then advised the defendant that she intended to notify the judge (the intended victim).[353] As per Florida's *Tarasoff*-model statute,[354] she contacted the judge and law enforcement.[355] The next day, defendant told the psychotherapist that he no longer had homicidal thoughts and he was released from the hospital.[356]

The court determined that while the psychotherapist's *Tarasoff* warning was "probably appropriate under [the state *Tarasoff*-model law, it] was not the only means by which harm to the judge could have been averted at the time the disclosure was made."[357] This was because defendant was in a locked psychiatric ward, while the gun he intended to use to carry out his plan was at his home.[358] And if he attempted to leave the hospital, he would have been involuntarily committed.[359] Thus, the court concluded that the facts did not fall "[u]nder the test pronounced by the Court in *Jaffee*, and applied in *Glass*."[360]

In a more recent case, *United States v. Hardy*,[361] the U.S. District Court for the District of Maine also recognized the dangerous-patient exception

348. *Id.* at *2.
349. *Id.* at *3.
350. *Id.* at *1.
351. *Id.*
352. *Id.*
353. *Id.*
354. *See* FLA. STAT. § 456.059(3) (1999) (formerly FLA. STAT. § 455.671) (amended 2000).
355. *Highsmith*, 2007 WL 2406990, at *1, *3.
356. *Id.* at *1.
357. *Id.* at *3 (citing United States v. Glass, 133 F.3d 1356, 1360 (10th Cir. 1998)).
358. *Id.*
359. *Id.*
360. *Id.*
361. No. 09-72-P-JHR, 2009 WL 2356685 (D. Me. July 30, 2009).

under the *Glass* test and decided to admit the psychotherapist's testimony about his patient's threat.[362] A psychiatric hospital patient was overheard making threats about President George W. Bush, President George H.W. Bush, the Pope, Senator John McCain, and hospital staff.[363] He also told a staff psychiatrist that he was going to Washington, D.C., to cut these people's heads off and to shoot them,[364] and in fact, he was concealing a large knife on his person when he was admitted to the hospital.[365] Hospital staff reported his threats to federal agents.[366] The defendant was involuntarily committed "for psychiatric treatment on the basis that he was a threat to others, due to the threats that he had made."[367]

On May 11, 2008, a federal agent interviewed the defendant and was told that the two Presidents Bush and other government officials "sought his demise."[368] Hardy told the agent he had had a hunting knife and recently had tried to acquire a firearm but was unsuccessful; he also said that he planned to go to Washington, D.C., upon his release from the hospital.[369]

On May 21, 2008, the hospital planned to release him due to what they believed to be his stabilized condition, but the defendant became agitated and began to threaten staff members.[370] He was also overheard using the telephone to obtain the telephone number for a gun shop.[371] As a result, his involuntary commitment was reissued, but nine days later he was transferred to a different hospital.[372] Two weeks later he was discharged and placed on a bus to Cleveland, Ohio.[373] Shortly after his arrival in Ohio, he was hospitalized for seven months.[374] When he was discharged, he went to a supervised group home, but stayed only for a few hours, leaving behind all of his belongings.[375] Five months later, the defendant was arrested for his initial threats.[376]

In *Hardy*, the court determined that the initial threat was serious because the psychotherapist immediately informed the Secret Service of the threat, contrary to the ten-day delay in *Glass*.[377] However, it also noted that the Secret Service and the government prosecutors did not seek to arrest the defendant until over five months after he left the treatment center, "suggesting that the threat was not viewed, at least by them, to be serious or

362. *Id.* at *4.
363. *Id.* at *2.
364. *Id.*
365. *Id.* at *1.
366. *Id.* at *3–4.
367. *Id.* at *2.
368. *Id.*
369. *Id.*
370. *Id.*
371. *Id.*
372. *Id.*
373. *Id.*
374. *Id.*
375. *Id.*
376. *Id.*
377. *Id.* at *4.

its danger imminent."[378] Despite this, the court concluded the "dangerous defendant" exception to the privilege should be recognized.[379]

B. *Circuit Opinions: Even After Advising Patient of a Psychotherapist's* Tarasoff *Duty, a Psychotherapist's Testimony Is Barred Because a Patient's Threat Is Still Privileged*

The majority opinions in both the Sixth Circuit and the Ninth Circuit have held that a patient's threats communicated to a psychotherapist, which require the therapist to give a *Tarasoff* warning, are privileged, even if the communication is made after the patient received an advisory about the *Tarasoff* warning.

1. Sixth Circuit: *United States v. Hayes*

The Sixth Circuit rejected a dangerous-patient exception by holding that "compliance with the professional duty to protect does not imply a duty to testify against a patient in criminal proceedings."[380] That is, there is

> only a marginal connection, if any at all, between a psychotherapist's action in notifying a third party (for his own safety) of a patient's threat to kill or injure him and a court's refusal to permit the therapist to testify about such threat (in the interest of protecting the psychotherapist/patient relationship) in a later prosecution of the patient for making it.[381]

In *United States v. Hayes*, the defendant was prosecuted for making threats during psychotherapy treatment sessions that he would murder his supervisor, a federal official, at the U.S. Postal Service.[382] During therapy sessions, patient Roy Lee Hayes shared detailed plans of how he would murder his boss, despite his social worker's repeated advice that his threat could not be kept confidential.[383] The Sixth Circuit held that it was proper for Hayes to invoke privilege to bar the psychotherapist's testimony for several reasons.

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378. *Id.*
379. *Id.*
380. United States v. Hayes, 227 F.3d 578, 586 (6th Cir. 2000).
381. *Id.* at 583–84.
382. *Id.* at 579–81.
383. *Id.* at 580. The social worker claimed to have advised Hayes that he "had a duty to warn affected third parties should he determine that Hayes posed a serious threat to himself or others." *Id.* Even after this advice, Hayes revealed to the social worker that he still wanted to murder his supervisor and also described in detail how he planned to do it; however, the social worker determined that this was not a serious threat. *Id.* In a follow-up session several days later, Hayes again outlined in great detail his plan to kill his supervisor, this time describing the layout of her home and how he knew when she would be home alone. *Id.* The social worker again advised Hayes that serious threats like that would not be kept confidential. *Id.* The social worker waited until the next day to confer with his legal counsel and then decided to warn the supervisor that she may be in danger. *Id.*

a. Sixth Circuit: No Dangerous-Patient Exception to Privilege

The *Hayes* court held that making an exception to privilege would harm the treatment relationship with the patient.[384] The court stated that "the chilling effect that would result from the recognition of a 'dangerous patient' exception and its logical consequences is the first reason to reject it."[385] "A patient consulting a psychotherapist might fear that disclosing information would cause the therapist to decide the patient was 'dangerous' and disclose the confidential information to authorities."[386]

The Sixth Circuit argued that the *Jaffee* footnote recognized two interests at stake: the fostering of effective mental healthcare by open dialogue and the protection of innocent parties.[387] It questioned whether an exception would actually serve the public ends that would justify the means.[388] Allowing a psychiatrist to testify would not protect a third party from harm because the threat would have already passed by the time of trial.[389] The Sixth Circuit held that there was little correlation between a state's *Tarasoff* duty requirement and the applicability of the psychiatrist-patient privilege in criminal proceedings.[390] A *Tarasoff* duty carries out a far more immediate function than the proposed dangerous-patient exception, whereas the threat is unlikely to be carried out once court proceedings have begun.[391]

Instead, the Sixth Circuit interpreted the *Jaffee* footnote narrowly, asserting that it could only mean privilege would give way when a psychotherapist needs to testify in involuntary commitment hearings.[392] Applying an exception to privilege only in the context of involuntary commitment hearings would be more consistent with the principles and policy judgments of *Jaffee*.[393] Making an exception to allow testimony in the context of involuntary commitment hearings would serve two public ends: protecting a third party that would otherwise have been in danger and fostering treatment that may ultimately improve the patient's mental state

384. *Id.* at 584–85.
385. *Id.* at 585.
386. Aronson, *supra* note 319, at 605; *see also Hayes*, 227 F.3d at 584–85.
387. *Hayes*, 227 F.3d at 585.
388. *Id.*
389. *Id.*
390. *Id.* at 583–84.
391. *Id.*; *see* Anthony Parsio, Note, *The Psychotherapist-Patient Privilege: The Perils of Recognizing a "Dangerous Patient" Exception in Criminal Trials*, 41 NEW ENG. L. REV. 623, 650 (2007); *see also id.* at 652 (stating that testimony would have "little-to-no impact on protecting a victim," because it does not provide additional protection beyond the *Tarasoff* required warning).
392. *Hayes*, 227 F.3d at 585. An involuntary commitment hearing and a criminal trial are similar in that the patient no longer poses a threat of harm to others by the time of the proceeding; however, an important difference is that hospitalization has the potential to improve mental health. *Id.*
393. *See* Daniel M. Buroker, Note, *The Psychotherapist-Patient Privilege and Post-*Jaffee *Confusion*, 89 IOWA L. REV. 1373, 1388 (2004).

without leaving a stigma.[394] If a psychotherapist's testimony is used to incarcerate a patient, the court reasoned, then a patient will be less likely to seek and trust the mental health profession.[395]

The Sixth Circuit drew further support from the fact that a federal dangerous-patient exception would be at odds with the majority of state laws that do not recognize such an exception in state privilege law.[396] A dangerous-patient exception was glaringly missing from Proposed Federal Rule of Evidence 504, which initially proposed the creation of a federal psychotherapist privilege.[397]

b. *Sixth Circuit: A Patient's Threat Communicated to a Psychotherapist Is Privileged, Even After an Advisory About a* Tarasoff *Duty*

In *Hayes*, the Sixth Circuit rejected the government's alternative argument that, even if the dangerous-patient exception did not apply in the case, Hayes could not claim that he reasonably expected his threats to remain confidential because his psychotherapist had advised him of her *Tarasoff* duty to protect.[398] The Sixth Circuit acknowledged, "It is true that at the outset of psychotherapist/patient privilege, a therapist has a professional responsibility to disclose to a patient 'the relevant limitations on confidentiality.'"[399] However, "[i]t is one thing to inform a patient of the 'duty to protect'; it is quite another to advise a patient that his 'trusted' confidant may one day assist in procuring his conviction and incarceration."[400] Because "[n]one of Hayes's psychotherapists ever informed him of the possibility that they might testify against him . . . Hayes cannot be said to have 'knowingly' or 'voluntarily' waived his right to assert the psychotherapist/patient privilege here."[401] The Sixth Circuit held that Hayes's psychotherapist could not testify in his criminal prosecution, unless he agreed that she may do so by valid waiver of the privilege.[402] A valid waiver would be grounded in a specific instruction to the patient, not simply about the *Tarasoff* duty to warn, but also "an explanation of the consequences of that waiver suited to the unique needs of that patient."[403] The court found that there is no "'magic formula' for securing a valid waiver," for "the 'magic words' necessary to acquaint an

394. *Hayes*, 227 F.3d at 585 ("Once in prison, even partly as a consequence of the testimony of a therapist to whom the patient came for help, the probability of the patient's mental health improving diminishes significantly and a stigma certainly attaches after the patient's sentence is served.").

395. *Id.*

396. *Id.*

397. *Id.* at 585–86 (citing Rules of Evidence for United States Courts and Magistrates, 56 F.R.D. 183, 241 (1972)).

398. *Id.* at 586.

399. *Id.* at 586 (quoting AM. PSYCHOLOGICAL ASS'N, *supra* note 261, Standard 5.01).

400. *Id.*

401. *Id.*

402. *Id.* at 587. It is the patient alone who has the authority to waive privilege. *Id.*

403. *Id.*

individual, who may have serious mental or emotional problems, with the psychotherapist/patient privilege and the consequences of waiving that privilege will obviously vary from case to case."[404]

The Sixth Circuit asserted that this type of full advisory would certainly have a deleterious effect upon the treatment relationship.[405] "While early advice to the patient that . . . a duty to protect [may arise would only] have a marginal effect on the patient's candor in therapy sessions, an additional warning that the patient's statements may be used against him in a subsequent criminal prosecution would certainly chill and very likely terminate open dialogue."[406]

2. Ninth Circuit: *United States v. Chase* (Majority Opinion)

The Ninth Circuit has also held that the federal psychotherapist-patient privilege precludes testimony at trial even where the patient communicates threats after he is provided with an advisory about a *Tarasoff* duty.[407] In *United States v. Chase*, the patient was convicted of making threats against FBI agents.[408] Chase suffered from episodes of rage and obsessive behavior and had been in psychotherapy for several years.[409] During a therapy session, he showed his psychiatrist his day planner, which included the names, addresses, and social security numbers of two FBI agents who he was considering killing.[410] Although he told his therapist that he did not plan to act on his thoughts, the therapist advised the patient that if he provided "specifics about whom he planned to kill, that she would have a duty to disclose the threats to the intended victims so that they could protect themselves."[411]

At some point, it became apparent that Chase was becoming more frustrated and angry, and that he may act on his threat.[412] The psychotherapist acted on her *Tarasoff* duty and notified law enforcement about Chase's threat.[413] When the psychotherapist and Chase met again for a follow-up therapy session, the psychotherapist did not tell Chase that she had disclosed his threats to the law enforcement authorities.[414] In fact, the psychotherapist's supervisor had advised her "to continue to cooperate with the authorities and to attempt to elicit more information" from the patient

404. *Id.*
405. *See id.* at 584–85 (citing Gregory B. Leong, Spencer Eth & J. Arturo Silva, *The Psychotherapist as Witness for the Prosecution: The Criminalization of* Tarasoff, 149 AM. J. PSYCHIATRY 1011, 1014 (1992)).
406. *Id.*
407. United States v. Chase, 340 F.3d 978, 988 (9th Cir. 2003) (en banc).
408. *Id.* at 979.
409. *Id.*
410. *Id.*
411. *Id.*
412. *Id.* at 979–80.
413. *Id.* at 980.
414. *Id.*

regarding his plans.[415] In the next session the patient revealed more about his plans, and the psychotherapist again advised the patient about her duty to warn Chase's intended victims.[416] Chase "alternated between claiming that he did not have any plans to act immediately and reiterating his threats."[417] The Ninth Circuit held that it was error (although harmless) for the district court to allow the psychotherapist to testify about privileged communication.[418]

a. *Ninth Circuit: No Dangerous-Patient Exception to Privilege*

The Ninth Circuit held that Chase's communication to his psychotherapist regarding threats to third parties was a confidential communication subject to federal testimonial privilege.[419] It did not recognize a dangerous-patient exception to privilege.[420] Thus, when a psychotherapist breaches confidentiality, it does "not necessarily lead to an abrogation of the federal testimonial privilege."[421]

The Ninth Circuit stated that creating a privilege exception would have "some adverse effect on the candor that the psychotherapist-patient privilege is meant to encourage, because patients will be more reluctant to divulge unsavory thoughts or urges if they know that the therapist may be required to testify about the content of therapeutic sessions."[422] The court also stated that the harm to the third party would have likely dissipated by the time the court proceedings had begun.[423]

Similar to the Sixth Circuit's holding in *Hayes*, the Ninth Circuit also looked to the original Proposed Federal Rule of Evidence 504 from 1972, which outlined only three exceptions to the proposed psychotherapist privilege, none of which included a dangerous-patient exception.[424] Also, because the *Jaffee* Court favorably cited Proposed Rule 504, it has "'considerable force and should be consulted when the psychotherapist-patient privilege is invoked.'"[425] It stated that the Advisory Committee's omission of a dangerous-patient exception from the Proposed Rule was

415. *Id.*
416. *Id.*
417. *Id.*
418. *Id.* at 979.
419. *Id.* at 982.
420. *Id.* at 981.
421. *Id.* at 985. See also *United States v. Lincoln*, 403 F.3d 703 (9th Cir. 2005), for an additional opinion where the U.S. Court of Appeals for the Ninth Circuit excludes a psychotherapist's testimony about a patient's threats on the basis that there is no dangerous-patient exception, relying on *United States v. Chase*.
422. *Chase*, 340 F.3d at 990.
423. *Id.* at 987 ("If a patient was dangerous at the time of the *Tarasoff* disclosure, but by the time of trial the patient is stable and harmless, the protection rationale that animates the exception to the states' confidentiality laws no longer applies.").
424. *Id.* at 989 (citing Rules of Evidence for United States Courts and Magistrates, 56 F.R.D. 183, 241 (1972)).
425. *Id.* at 990 (quoting 3 JACK B. WEINSTEIN & MARGARET A. BERGER, WEINSTEIN'S FEDERAL EVIDENCE § 504.02, at 504–07 (2d ed. 1997)).

likely deliberate based on the persuasive logic that therapy would not be effective if patients were unable to speak freely for fear of possible disclosure later on at a criminal proceeding.[426] Furthermore, an exception would not be in line with most state privilege laws.[427]

The Ninth Circuit majority opinion also thought it would be problematic to base federal privilege on the *Glass* standard (the threat is serious when uttered and the disclosure is the only means of averting harm) because *Tarasoff*-model laws are so varied among states. "[A]s a practical matter, the fact that different states have different standards regarding when a psychotherapist must (or may) breach confidentiality by disclosing a patient's threats counsels against hinging the *Jaffee* testimonial privilege on the protective disclosure laws of the states."[428] "If the federal evidentiary privilege were tied to the states' disclosure laws, then similarly situated patients would face different rules of evidence in federal criminal trials."[429] Furthermore, "[t]he Federal Rules of Evidence should apply uniformly and not vary depending on the state in which the defendant resides."[430]

b. *Ninth Circuit: A Patient's Threat Communicated to a Psychotherapist Is Privileged, Even After an Advisory About a* Tarasoff *Duty*

The Ninth Circuit determined that Chase's communication to his psychotherapist regarding threats to third parties was a confidential communication subject to federal testimonial privilege.[431] The court acknowledged that the strongest argument in favor of allowing testimony is when the psychotherapist has specifically informed the patient that he will not keep communication confidential.[432] The court characterized the logic of this argument as follows: "if the patient knows that the psychotherapist can disclose threats to third parties that the patient communicates during treatment, then the patient has no expectation of confidentiality in the first place when communicating the threats; therefore, there is no reason to treat such communications as 'privileged.'"[433] The Ninth Circuit called it "a cousin to a common analysis of the waiver of a privilege."[434]

The court attacked this theory on two grounds. First, the logic "relies to some extent on a [legal] fiction that the patient knows that a disclosure for one purpose (warning a potential target of violence) is a disclosure for all purposes (including incriminating testimony in a federal criminal trial)."[435]

426. *See id.* at 989; *see also id.* at 990 (citing Leong et al., *supra* note 405, at 1014).
427. *Id.* at 985–86.
428. *Id.* at 987.
429. *Id.*
430. *Id.* at 988.
431. *Id.* at 981.
432. *Id.* at 988 (construing United States v. Hayes, 227 F.3d 578, 587 (6th Cir. 2000) (Boggs, J., dissenting)).
433. *Id.* (quoting 2 CHARLES MCCORMICK, MCCORMICK ON EVIDENCE § 93, at 371–72 (5th ed. 1999)).
434. *Id.*
435. *Id.*

The psychotherapist did not inform Chase that she might testify against him in court; she simply advised the patient that she would disclose his threats for the purpose of protecting intended victims.[436] Therefore, this could not be a valid waiver of the privilege because the patient was not informed about the consequence that a *Tarasoff* duty would entail loss of privilege. The court acknowledged that arguably, "if a psychotherapist informed a patient ahead of time that she would testify in court; [then] the patient . . . would be agreeing that the subsequent communication was not confidential."[437] Regardless, the implications of such advice to the patient would seriously harm the therapeutic relationship by chilling the patient's trust and open dialogue with his psychotherapist.[438] Accordingly, the court thought that "a patient [would] retain significantly greater residual trust when the therapist [could] disclose only for protective, rather than punitive, purposes."[439]

Second, the Ninth Circuit also stated that it was problematic to base the existence of a privilege on the patient's knowledge of the law.[440] "[T]o the extent that a patient actually does know the law and the rules of evidence, the legal rule itself, whatever it may be, will govern the patient's expectations."[441] This essentially reframes the patient's expectations in terms of whether a patient believes his communication will be privileged rather than whether it will be kept confidential. The Ninth Circuit proposed, "If, for example, the operative legal rule is that a therapist may disclose threats in order to warn intended victims, but may not testify to the threats in federal court—the analogue to the rule in most states—that is the rule that the patient will assume is in effect."[442]

C. *Circuit Opinions: Testimony Allowed Because a Patient's Threat Communicated to a Psychotherapist Is Not Privileged After an Advisory About a Psychotherapist's* Tarasoff *Duty*

Whereas both the Sixth and Ninth Circuits held that communication is privileged despite the patient's knowledge that the communication will be disclosed to a third party, other opinions depart from these holdings.[443] Most recently, in *United States v. Auster*, the Fifth Circuit decided that such a communication cannot be privileged if the patient is aware that it will not be kept confidential when the patient communicates the threat to his psychotherapist.[444] Even before *Auster* was decided in 2008, the dissenting

436. *Id.* at 988 n.5.
437. *Id.*
438. *See id.* at 990 (citing Leong et al., *supra* note 405).
439. *Id.*
440. *Id.* at 988.
441. *Id.*
442. *Id.* at 988–89.
443. *See, e.g.*, United States v. Auster, 517 F.3d 312, 316–17 (5th Cir.) (criticizing those decisions as effectively asserting that "confidentiality is not a requirement for the applicability of the psychotherapist-patient privilege"), *cert. denied*, 129 S. Ct. 75 (2008).
444. *See Auster*, 517 F.3d at 315–16.

opinion of *Hayes* and the concurring opinion of *Chase* voiced support for this position.

1. Opinions Prior to *United States v. Auster*

a. *Sixth Circuit:* United States v. Hayes *(Dissenting Opinion)*

In the dissent of *United States v. Hayes*, Judge Danny J. Boggs argued that when a psychotherapist specifically informs the patient that she cannot by law keep certain communications confidential, there is no barrier to the psychotherapist testifying.[445] In *Hayes*, the patient was advised three separate times that his threats "would not and could not be kept in confidence,"[446] and yet, "Hayes went on, in the face of the warning, to detail exactly how he planned to waylay and kill [his supervisor]."[447] Hayes had "ample notice that such discussion was outside the [limits] of any promised or assumed confidentiality."[448]

Judge Boggs reasoned, "The fact that [the psychotherapists] did not use magic words like 'I can testify in court about what you tell me' . . . should not be decisive."[449] In fact, he stated that it is a misconstruction to view it as a constructive waiver.[450] Instead, "Hayes waived any privilege purely and simply, by continuing to threaten after he had been given notice that his threats would not be held in confidence."[451]

Judge Boggs also addressed the possibility that there would be a chilling effect if patients knew that certain communications would not be privileged. He proposed that, by not allowing psychotherapists to testify about anything said up to the point at which notice is given that the threat is "no longer covered by confidentiality," patients would still be encouraged to confide in mental health professionals.[452]

Furthermore, Judge Boggs was not dissuaded from his opinion simply because the act of making a threat is not a traditional *malum in se* crime.[453] He stated that threats after a warning of nonconfidentiality are no different in nature than making similar threats to a fellow drinker at a bar or to one's lawyer.[454] When the commission of the crime itself is making the threat, the psychotherapist himself is implicated in the commission of the crime if the patient knows about the psychotherapist's duty to warn.[455] It would be

445. United States v. Hayes, 227 F.3d 578, 587 (6th Cir. 2000) (Boggs, J., dissenting).
446. *Id.* at 588.
447. *Id.*
448. *Id.*
449. *Id.*
450. *Id.*
451. *Id.* at 589.
452. *Id.*
453. *Id.* at 588.
454. *Id.*
455. *See id.* at 589; *see also* Paul Herbert, *Letter to the Editor*, 31 J. AM. ACAD. PSYCHIATRY & L. 524 (2003) (asserting that without a criminal threat statute, the *Tarasoff*

odd to allow a criminal to perpetrate crimes (the threats) via a psychotherapist "with no opportunity for the listener to avoid facilitating the crime."[456] Judge Boggs stated that no "tender concern for criminal evidence is required by the common law, or by reason and experience, when the patient has been put on notice."[457]

b. *Ninth Circuit:* United States v. Chase *(Concurring Opinion)*

Judge Kleinfeld's concurrence in *United States v. Chase* was akin to Judge Boggs's dissent in *Hayes*. Although the concurring opinion favored recognition of a dangerous-patient exception, under the *Glass* reasoning,[458] the opinion also acknowledged that an advisory about the limits of confidentiality (which would presumably include advice that a *Tarasoff* duty means sharing the patient's threats with third parties) would certainly determine the status of the communication's privilege. "[B]y communicating after the psychotherapist had told him she would not keep the communications secret" the patient waived his privilege.[459]

Judge Kleinfeld reasoned that it does not make sense for the privilege to remain in force, even though disclosure is made to third parties, and especially if the defendant knows the disclosure is made.[460] The opinion reasoned that, under the circumstances, once the targeted person who "the deranged individual hates so much that he plans to kill him knows his secrets," and also once "the deranged individual knows that his psychotherapist refuses to keep his secrets from that person, there is not much therapeutic value in refusing later to tell this already-disclosed information to the judge and jury."[461] Indeed, "the therapeutic relationship is not the only social value at stake" since "prospective victims' lives are [also] at stake."[462]

Furthermore, the concurring opinion reasoned that it is doubtful that patients would stop therapy when they find out that a psychotherapist is going to testify against them. Any chilling effect "will doubtless already have occurred where the psychotherapist betrayed their confidences to their worst enemies" by breaking confidentiality to comply with a *Tarasoff*-required warning.[463]

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duty "would invite every antisocial grudge-holder to launder his threats through a psychiatrist and thereby to harass his victim with impunity"). Judge Danny J. Boggs also cautioned that "[i]f the real problem is that we don't think that this type of threat, alone, is a very serious matter, then that is for Congress." *Hayes*, 227 F.3d at 589.

456. *Hayes*, 227 F.3d at 589.

457. *Id.* at 588.

458. *See supra* Part II.A.2.

459. *See* United States v. Chase, 340 F.3d 978, 996 (9th Cir. 2003) (Kleinfeld, J., concurring) (stating that communication to a psychotherapist on express terms that the communication will be disclosed is an unprivileged communication).

460. *Id.* at 996–97.

461. *Id.* at 997.

462. *Id.*

463. *Id.*

2. Fifth Circuit: *United States v. Auster*

In 2008, the Fifth Circuit decided *United States v. Auster*.[464] In the case, a psychotherapist advised his patient that he would have to disclose the patient's threat in accordance with a *Tarasoff* duty to warn.[465] The Fifth Circuit determined that there could be no privilege when the patient's statement was not intended to be confidential.[466] It did this without deciding whether there was a dangerous-patient exception.[467] This is the first majority opinion in the federal circuit courts to take such a position.

John C. Auster was a retired police officer who had been receiving workers' compensation benefits for many years.[468] He was also in long-term therapy for paranoia, anger, and depression.[469] In fact, over the years, Auster had made several threats of violence against others during his therapy.[470] Whenever this occurred, Auster's therapist always told him that if his threats were serious they would not be kept confidential because the therapist would be required to warn those in danger.[471]

When Auster started to have problems with receiving his benefits for his disability from work, it clearly became a source of anger for him.[472] With full knowledge that his therapist would convey his threat to its target, Auster told his psychotherapist that "unless the managers of his workers compensation claim continued to pay the benefits that he believed he was owed, he would 'carry out his plan of violent retribution' against them and others."[473] Consistent with the *Tarasoff* duty required by Louisiana statute,[474] his therapist wrote a letter of warning to the claim managers stating,

> I have had to exercise my duty to warn, with [Auster's] knowledge, several times when he was in danger of acting violently . . . . Mr. Auster is well aware of my position regarding violence and has agreed that he understands that I have such an obligation. This understanding has not interfered in his reporting of homicidal intentions in the past.[475]

The court found this letter informative for several reasons. The letter demonstrated that Auster knew that his threats would be communicated to his targets.[476] It showed that the psychotherapist had advised his patient

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464. 517 F.3d 312 (5th Cir.), *cert. denied*, 129 S. Ct. 75 (2008).
465. *See id.* at 313.
466. *Id.* at 315.
467. *See id.*
468. *Id.* at 313.
469. *Id.*
470. *Id.*
471. *Id.* at 313 n.2.
472. *See id.* at 313.
473. *Id.*
474. *Id.* at 316 n.9 (quoting LA. REV. STAT. ANN. § 9:2800.2).
475. *Id.* at 313 n.2 (alteration in original).
476. *Id.* at 313, 315, 316. In fact, there was additional evidence presented during arguments at the district court level: when his therapist told Auster that he had warned the

about his *Tarasoff* duty to warn, in order to inform him as to the limits of confidentiality.[477] Also, the last line of the letter clearly demonstrated that this patient was not dissuaded from sharing certain information like this with his psychotherapist.[478] In fact, he intended for the information to be shared.[479] Auster was charged with extortion, under federal law 18 U.S.C. § 1951, on the basis that he made the threat with full knowledge and intent that the therapist would convey it to the claims manager.[480]

The Fifth Circuit relied on basic theory about evidentiary privileges. It stated that all privileges "'must originate in a confidence that [communications] will not be disclosed.'"[481] "[W]ithout such a reasonable expectation [of confidentiality,] there is no privilege."[482] The operative test is "whether there was a 'reasonable expectation of confidentiality' when the statement was made."[483]

The court also relied on *Jaffee*'s explicit requirement that there must be "'*confidential* communications made to licensed [psychotherapists] . . . in the course of psychotherapy'" in order to determine if privilege exists.[484] A per se rule requiring confidentiality before the privilege is applicable is appropriate under the *Jaffee* holding.[485] Accordingly, the court concluded that, "[a]s a matter of law, where the confidentiality requirement has not been satisfied, the psychotherapist-patient privilege . . . does not apply."[486] Thus, "a defendant cannot claim the protections of the psychotherapist-patient privilege if he had actual knowledge, when making the statements, that they would not be kept confidential."[487] The Fifth Circuit also called attention to footnote twelve in the *Jaffee* decision, which acknowledged the psychotherapist's ethical duty to instruct the patient as to the relevant limits of confidentiality.[488]

In this case, "[Auster] knew he was making a threat of physical violence against specific victims to commence on a specific date . . . [and] that his statement was of the sort that [his psychotherapist] had a duty to

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intended target, Auster's lawyer conceded to the court that "he had expected that [his therapist] would do just that" when he made the threat. *Id.* at 313 n.2.

477. *See infra* note 488 and accompanying text.

478. *See Auster*, 517 F.3d at 313 n.2.

479. *See id.* at 318–19.

480. *Id.* at 314.

481. *Id.* at 315 n.6 (quoting 1 CHARLES MCCORMICK, MCCORMICK ON EVIDENCE § 72 (6th ed. 2006)).

482. *Id.* at 316.

483. *Id.* at 317.

484. *Id.* at 315 (quoting Jaffee v. Redmond, 518 U.S. 1, 15 (1996)).

485. *See id.* at 318 n.17 ("By both expressly noting the possibility of waiver and tying the psychotherapist-patient privilege to other testimonial privileges (which all require that the statements be made in confidence), the [*Jaffee*] Court reiterated the fundamental nature of confidentiality."). Indeed, since *Jaffee*, federal case law has further developed this test within the context of the psychotherapist-patient relationship. *See supra* Part I.A.4.a (discussing recent case law).

486. *Auster*, 517 F.3d at 315 & n.6.

487. *Id.* at 320.

488. *Id.* at 316 n.10 (citing *Jaffee*, 518 U.S. at 13 n.12).

disclose."[489] Thus, "[u]nder these circumstances, any expectation of confidentiality would have been 'manifestly unreasonable.'"[490] The Fifth Circuit held that "Auster's non-confidential statement cannot, as a matter of law, be privileged."[491]

The Fifth Circuit defended its holding on several grounds. A chilling effect regarding the patient's willingness to trust the psychotherapist was predicted by both the *Hayes* and *Chase* majority opinions.[492] The court concluded that these other circuit decisions had offered no rationale for their belief that many patients willing to disclose violent impulses even upon learning of the *Tarasoff* duty would decline to do so once advised that their psychotherapists could have to testify against them in the event they acted on those impulses.[493] The court pointed out that psychological literature did not reflect this outcome.[494] Instead, the Fifth Circuit held, "'Those patients who remain in therapy even after being advised of the limits on confidentiality typically do so because they recognize their need for help and believe that psychotherapy may provide it.'"[495]

The court reasoned that there would already be a chilling effect from the psychotherapist having to comply with a legally required *Tarasoff* warning to third parties.[496] "If the therapist's professional duty to thwart the patient's plans has not already chilled the patient's willingness to speak candidly, it is doubtful that the possibility that the therapist might also testify in federal court will do so."[497] Therefore, the court concluded that the marginal increase in effective therapy by allowing a *Tarasoff* duty but still privileging the communication is de minimis.[498] And further, when a patient is aware that a *Tarasoff* warning might be issued if a threat were made, the benefit that inheres from protecting the patient's disclosure may be outweighed by the cost of reducing the probability of conviction.[499] The court also recognized that the psychotherapist's testimony during a criminal

489. *Id.* at 316 n.11.

490. *Id.* (quoting United States v. Robinson, 121 F.3d 971, 976 (5th Cir. 1997)); *see id.* at 313 (stating that "Auster had no reasonable expectation of confidentiality when he made his threat"); *id.* at 315 (elaborating further that Auster had "no reasonable basis to conclude that the statement was confidential").

491. *Id.* at 321; *see id.* at 316 n.7 (reviewing the following case facts: the psychotherapists advised that his threats of violence would be communicated to his target, informed him that they have a legal duty to convey his threats to those at risk, and, lastly, Auster signified his understanding and agreement that the psychotherapists had such an obligation).

492. *See supra* text accompanying note 406 (regarding the *Hayes* opinion); *see also supra* text accompanying note 438 (discussing the *Chase* majority opinion).

493. *Auster*, 517 F.3d at 318 n.18 (quoting Comment, *Evidence*, *supra* note 203, at 2199).

494. *Id.* (quoting Comment, *Evidence*, *supra* note 203, at 2199).

495. *Id.* (quoting Comment, *Evidence*, *supra* note 203, at 2199).

496. *See id.* at 318–19 ("[K]nowing that anyone, or everyone, might be privy to the secret will embarrass the patient and will detrimentally affect his relationships with others.").

497. *Id.* at 318.

498. *Id.* at 319.

499. *See id.* at 317–18, 319 & n.24 (stating that "where a patient has no reasonable expectation of confidentiality, the cost-benefit scales favor disclosure"); *see also* Appelbaum, *supra* note 151, at 715.

proceeding would be substantially valuable in cases like *Auster*, where the threat was serious and imminent enough to trigger a *Tarasoff* duty.[500]

The Fifth Circuit responded to the argument that a legitimate waiver of testimonial privilege would require a more complete advisory than simply advising that threatening communications would not be held in confidence.[501] The Ninth Circuit had called it a legal fiction that the patient would know that a disclosure for one purpose is a disclosure for all purposes.[502] The Fifth Circuit disagreed and cautioned against trying to "interpret 'confidential' to mean merely confidential-at-law and not (the more intuitive) confidential-in-fact."[503] More importantly, somehow giving the two different meanings is pointless, since the policy argument fails: that is, the slight marginal benefit of keeping communication privileged where the patient knows that the threat not being kept confidential is substantially outweighed by the costs.[504] Instead, calling attention to this "legal fiction" is more of "a doctrinal *cul-de-sac*, interesting but leading nowhere."[505]

Where the Sixth and the Ninth Circuits would recognize communication as privileged even after the patient was given an advisory about the psychotherapist's legally required *Tarasoff* duty, the Fifth Circuit further criticized additional arguments. For example, the other circuits argued that it was problematic that states have differently defined *Tarasoff*-duty statutes, since it would mean that "similarly situated patients would face different rules of evidence in federal criminal trials."[506] The Fifth Circuit concluded that "[f]ederal law does not depend on state law but instead is turning on the lack of confidentiality regardless of the reason."[507] Where the Sixth and Ninth Circuits pointed out that the majority of states would not find a dangerous-patient exception to privilege,[508] the Fifth Circuit concluded that that there is no major consensus among the states regarding whether psychotherapists can testify about statements made without a reasonable expectation of confidentiality.[509]

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500. *Auster*, 517 F.3d at 319.

501. *See supra* notes 399–401 and accompanying text.

502. United States v. Chase, 340 F.3d 978, 988 (9th Cir. 2003) (en banc).

503. *Auster*, 517 F.3d at 319 n.24.

504. *Id.*

505. *Id.*

506. *Chase*, 340 F.3d at 987; *see* United States v. Hayes, 227 F.3d 578, 584 (6th Cir. 2000) (asserting it is not right for "the scope of a federal testimonial privilege [to] vary depending upon state determinations of what constitutes 'reasonable' professional conduct"); *see also supra* notes 428–30 and accompanying text.

507. *Auster*, 517 F.3d at 317.

508. *See supra* notes 144, 427 and accompanying text.

509. *See Auster*, 517 F.3d at 319–20. "In California 'a psychotherapist not only must disclose to authorities or intended victims the existence of a dangerous patient, [he] also may testify to threats made during the course of therapy.'" *Id.* at 320 (alteration in original) (quoting *Chase*, 340 F.3d at 986). Florida seems to follow California. *Id.* at 320 & n.27 (citing Guerrier v. State, 811 So. 2d 852, 855 (Fla. Dist. Ct. App. 2002)). Several other states appear to favor admission of a psychotherapist's testimony. *Id.* at 320 & n.28 (citing W. VA. CODE § 27-3-1; CONN. GEN. STAT. § 52-146c; WYO. STAT. ANN. § 33-27-123). *But see* State v. Orr, 969 A.2d 750, 764 (Conn. 2009) (recently deciding that social worker

Finally, the Fifth Circuit asserted that allowing psychotherapists to testify at civil commitment hearings, but disallowing testimony at criminal trials, lacks practical sense since "the nuance—in terms of trust and confidence—likely does not matter much to the fellow committed."[510] Furthermore, "it is unlikely that many patients will be dissuaded from seeking therapy by the additional chance that, aside from being committed against their will because of what they say to their therapists, they may also be criminally incarcerated based in part on those same statements."[511]

Although the Fifth Circuit declined to rule on whether there is a dangerous-patient exception to the psychotherapist-patient privilege, it did acknowledge that footnote nineteen in *Jaffee* clearly demonstrates that the Supreme Court viewed the privilege as limited in scope.[512] "Moreover, because the [Supreme] Court contemplated that the privilege must give way in some instances involving dangerous patients, even where there is confidentiality, it follows *a fortiori* that the privilege is inapplicable in similar situations involving dangerous patients where there is no confidentiality."[513]

3. Challenges to *Auster*

Auster was the first majority opinion at the federal circuit level to take the position that there could be no privilege when the patient's statement was not intended to be confidential, following an advisory to the patient about a psychotherapist's *Tarasoff* duty.[514] Since the Fifth Circuit's ruling, commentators believe that the "[d]ecision raises troubling questions in regard to what, if anything, patents are told at the inception of treatment about the boundaries of confidentiality, and puts a new spotlight on the previously unexplored implications of Footnote 12 in *Jaffee*," which acknowledges that psychotherapists have an ethical obligation to inform patients about the limits of confidentiality at the onset of therapy.[515]

On petition for certiorari to the Supreme Court, the amicus curiae brief for the National Association of Social Workers criticized the Fifth Circuit for improperly sidestepping application of the privilege "by redefining the meaning of confidentiality within a private therapy session" and rewriting

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testimony was inadmissible because there is no dangerous patient exception under the statutory privilege. In North Carolina, judges are allowed to decide on a case-by-case basis whether to exclude such evidence. *Auster*, 517 F.3d at 320 & n.29 (citing N.C. GEN STAT. § 8-53.3). And Texas does not even recognize a psychotherapist-patient privilege in any criminal proceedings. *Id.* at 320 & n.30 (citing TEX. R. EVID. 510).

510. *Auster*, 517 F.3d at 319.

511. *Id.*

512. *Id.* at 315 n.5.

513. *Id.*

514. *Id.* at 315.

515. Jaffee-Redmond.org, The Federal Psychotherapist-Patient Privilege (Jaffee v. Redmond, 518 U.S. 1): History, Documents, and Opinions, http://jaffee-redmond.org/ (last visited Sept. 24, 2009); *see* Pabian, Welfel & Beebe, *supra* note 184, at 12; Parke & Shankar, *supra* note 263.

the standard for the psychotherapist-patient privilege with its "novel ruling."[516] The Fifth Circuit held that the patient has no reasonable expectation of confidentiality, even if he is speaking in a private therapy session.[517] The brief argued that the *Auster* decision raises too many unanswered questions for therapists.[518] For example, "the Fifth Circuit did not define just how much information from the therapy session is left unprotected if a court deems a threat 'non-confidential'" since it is a social workers' ethical obligation not just to fulfill a *Tarasoff* warning if one is warranted, but also to preserve as much confidentiality as possible by disclosing the least amount of confidential information necessary.[519] The petition for certiorari was denied by the Supreme Court on October 6, 2008.[520]

III. RECOMMENDATION: NO PRIVILEGE SHOULD BE RECOGNIZED FOR THREATS DELIVERED TO A PSYCHOTHERAPIST AFTER A PATIENT IS ADVISED OF A *TARASOFF* DUTY

In all of the circuit cases discussed above in Part II,[521] the same fact pattern emerged. The patients indicated to their psychotherapists that they had thoughts (sometimes even concrete plans) to harm someone else.[522] Consistent with the *Tarasoff*-model state law in each of their states, the psychotherapists complied with their legal duties and issued warnings either to the third party at risk or law enforcement.[523] In *Hayes*, *Chase*, and *Auster*, the psychotherapists advised their patients that their profession is required, by law, to issue *Tarasoff* warnings.[524] And yet, these patients continued to communicate their threats to the therapists, even after receiving notice that this type of communication would not be held in confidence.[525] Evidently, they were not dissuaded by the lack of confidentiality. The circuits have diverged regarding whether the federal psychotherapist-patient privilege attaches to these repeated threats.[526]

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516. Brief for the National Association of Social Workers and the Louisiana Chapter of the National Association of Social Workers as Amici Curiae in Support of Petitioners, at 3 Auster v. United States, 129 S.Ct. 75 (2008) (No. 07-10877), 2008 WL 2435917, at *3.

517. *Id.* at 6.

518. *Id.* at 12.

519. *Id.*

520. Auster v. United States, 129 S. Ct. 75 (2008).

521. United States v. Auster, 517 F.3d 312 (5th Cir.), *cert. denied*, 129 S. Ct. 75 (2008); United States v. Chase, 340 F.3d 978 (9th Cir. 2003) (en banc); United States v. Hayes, 227 F.3d 578 (6th Cir. 2000); United States v. Glass, 133 F.3d 1356 (10th Cir. 1998).

522. *See supra* text accompanying notes 311, 321–22, 382–83, 473.

523. *See supra* notes 313, 383, 413, 474–75 and accompanying text.

524. *See supra* text accompanying notes 322, 383, 411, 471–73. An advisory to the patient about the psychotherapist's *Tarasoff* duty did not actually occur in *United States v. Glass*. Rather, the U.S. Court of Appeals for the Tenth Circuit decided that a dangerous-patient exception to privilege applies if the patient's threat was serious and the psychotherapist's *Tarasoff*-required warning was the only way to avert harm. *See supra* text accompanying notes 316–19.

525. *See supra* notes 322, 383, 478–79 and accompanying text.

526. *See supra* Part II.

This conflict turns on the consequence of psychotherapists' advising patients of the *Tarasoff* duty. Part III of this Note argues that the better approach is the Fifth Circuit's decision in *Auster*; that is, where a patient is advised that the psychotherapist will not keep his threats confidential due to a psychotherapist's *Tarasoff* duty, then the communication is not privileged. This part advocates that the holding in *Auster* is proper, based on the following justifications: (1) that privilege fails to exist, as a matter of law, when the patient does not intend for the communication to remain confidential after he received an advisory about a psychotherapist's *Tarasoff* duty, and (2) that despite the implications of this holding, psychotherapists can still implement procedures in their practice to minimize harm to the psychotherapist-patient treatment relationship.

A. *Privilege Does Not Exist Under These Circumstances, as a Matter of Law*

The holding in *Auster* is a straightforward application of privilege doctrine.[527] If a patient has notice that certain statements communicated to the therapist will not be held confidential, and he makes them regardless of this notice, then the communication "cannot, as a matter of law, be privileged."[528] One of the fundamental conditions that must be present for privilege to exist is that the communication originates in confidence.[529] The Fifth Circuit decided that a threatening statement made by a patient in therapy, after the patient is advised about a psychotherapist's *Tarasoff* duty, simply fails to meet the confidentiality requirement that justifies the privilege.[530]

Many patients enter therapy expecting absolute confidentiality.[531] Certainly, this expectation of confidentiality is at the heart of effective psychotherapy.[532] Confidentiality is blanketed simply by the nature of the relationship between psychotherapist and patient.[533] A psychotherapist-patient relationship originates in confidentiality. This was the very reason that the Supreme Court established the federal psychotherapist-patient privilege.[534]

However, it is overinclusive and wrong to assume privilege attaches to all communications in a confidential relationship. Wigmore's language is clear: the "communications" must "originate in confidence that they will

527. *See supra* notes 466, 481–87 and accompanying text.

528. United States v. Auster, 517 F.3d 312, 321 (5th Cir.), *cert. denied*, 129 S. Ct. 75 (2008); *see also supra* text accompanying notes 445, 451 (discussing Judge Boggs's dissent in *Hayes*); *supra* text accompanying notes 458–60 (discussing Judge Kleinfeld's concurrence in *Chase*).

529. *See supra* notes 21–28 and accompanying text.

530. *See Auster*, 517 F.3d at 315 n.6.

531. Both common sense and survey studies have shown this. *See supra* notes 76–77, 199–200 and accompanying text.

532. *See supra* text accompanying note 73.

533. *See supra* notes 76–77, 199–203 and accompanying text.

534. *See supra* notes 56–60, 64–67, 78–82 and accompanying text.

not be disclosed" in order to be privileged.[535] If a patient's threat is understood by the patient as not confidential at the very time it is communicated, then it cannot be privileged.[536] A nonconfidential privileged statement simply does not exist, with the exception of selective waiver doctrine—a concept that has really only found meaningful application to the attorney-corporate client relationship.[537]

It cannot be that the holding in *Auster* "redefin[ed] the meaning of confidentiality within a private therapy session," as suggested by the National Association of Social Workers' amicus brief to the Supreme Court.[538] Confidentiality has one meaning, and the Fifth Circuit was correct to point out that there should be no difference between a communication that is confidential as a matter of law versus one that is confidential as a matter of fact.[539] Once a psychotherapist advises a patient about his *Tarasoff* duty, any subsequent threats that are communicated to the psychotherapist do not "originate with the belief that they will not be discussed outside the office."[540]

In terms of privilege, it is an essential requirement that confidentiality attaches at the time of the communication, with an expectation that the communication will remain confidential in the future.[541] If the patient imparts a specific communication (such as a threat) that he has prior notice will be disclosed to others pursuant to a psychotherapist's *Tarasoff* duty, then how can he intend for it to remain a secret?[542] Furthermore, the test is whether the patient intends his communication to remain confidential, not whether he intends his communication to remain privileged.[543]

The cases in the circuit split discussed in Part II (with the exception of *Glass*) are notably analogous to the scores of cases involving police officers who underwent mandatory psychological examinations required by their employers.[544] In many of the latter cases, the officers were given advisories as to what level of confidentiality they could expect at the start of the employer-mandated treatment.[545] The *Whitney* case is particularly significant for comparison because it is common practice for psychotherapists working for the Massachusetts State Department of Youth Services to administer, what courts referred to as, "lack of confidentiality"

535. *See supra* note 22 and accompanying text.
536. *See supra* notes 78–82 and accompanying text.
537. *See supra* text accompanying notes 51–53.
538. Brief for the National Association of Social Workers and the Louisiana Chapter of the National Association of Social Workers as Amici Curiae in Support of Petitioners, *supra* note 516, at 3.
See supra text accompanying note 516.
539. *See supra* text accompanying note 503.
540. *See supra* text accompanying note 74.
541. *See supra* notes 29–32.
542. *See supra* text accompanying note 30.
543. *See supra* text accompanying note 32.
544. *See supra* Part I.A.4.a.
545. *See supra* Part I.A.4.a.; *see also supra* text accompanying note 107.

warnings to adolescent patients.[546] When the defendant in that case argued that the advisory was not sufficient for him to know that he was losing privilege in all subsequent communication after the advisory, the court refused to distinguish between nonconfidential in fact versus nonconfidential in law; instead, the Massachusetts District Court concluded that "[e]ither a communication is privileged from the outset, or it is not."[547]

In contrast, the majority opinions of both the Sixth and Ninth Circuits find a patient's repeated threat subsequent to an advisory about a *Tarasoff* duty insufficient to waive privilege.[548] These courts hold that only an advisory to a patient that includes notice as to the status of privilege could operate as a complete waiver of privilege.[549] Accordingly, only an advisory modeled on a *Miranda* warning (so that the advisory informed the patient that his threats could be used against him in court) would be sufficient to waive privilege.[550]

This logic fails on two levels. First, it confuses a waiver problem for a privilege problem by ignoring the fact that these communications did not originate in confidence (because of the advisory).[551] Second, even if these communications were considered to have originated in confidence, and were thus privileged, a waiver of privilege does not predicate knowledge of the privilege.[552] It is possible for a patient to implicitly waive privilege by making nonconfidential disclosures of information without an advisory like a *Miranda* warning.[553] As discussed in Part I.A.2, the holder of an evidentiary privilege can waive privilege even without ever being aware he had it.[554]

Admittedly, there may be an issue as to the patient's full understanding of an advisory about a psychotherapist's *Tarasoff* duty,[555] which is especially important in the context of a mentally ill patient. Even in the cases about employer- or court-mandated psychological exams, the therapists often secured oral or written waivers to evidence the patient's understanding and intention that their communication would not be

546. *See supra* text accompanying notes 128–29. These "lack of confidentiality" warnings, or *Lamb* warnings, are not required by law in the State of Massachusetts but, rather, are rather just common practice of the psychotherapists who work with this State Department. *See supra* text accompanying notes 128–29. Similarly, this Note focuses on the practice of psychotherapists advising their patients about their legal *Tarasoff* duty; the advisory is certainly not required by law, but seems to be a professional or ethical practice among psychotherapists.

547. *See supra* text accompanying note 132.

548. *See supra* notes 400–03, 434 and accompanying text.

549. *See supra* notes 38–43, 400–04, 435, 439 and accompanying text.

550. *See supra* notes 400–04, 435–39 and accompanying text.

551. *See supra* notes 41, 535–44 and accompanying text.

552. *See supra* notes 46–49 and accompanying text.

553. *See supra* note 137 and accompanying text.

554. *See Developments in the Law—Privileged Communications*, *supra* note 46, at 1629 n.1.

555. *See supra* note 146 and accompanying text.

private.[556] But in *Hayes*, *Chase*, and *Auster*, the issue was not raised as to the patient's lack of understanding regarding what the psychotherapist's *Tarasoff* duty signifies about confidentiality but, rather, what it means for the status of privilege. In fact, in *Auster*, the patient admitted that he fully understood and intended that his threat would be conveyed by his therapist to his intended victims so that they would take it seriously.[557] Thus, it is the patient's intent that his threats not be kept confidential that destroys the communication's privileged status. A more specific advisory, comprised of "magic words" that would be comparable to a *Miranda* warning for a psychotherapist is unnecessary as a matter of law.[558]

Of course, *Miranda* warnings would also place an unrealistic burden on psychotherapists.[559] A rule that "preserves the privilege, even where a patient has received a clear warning not to expect confidentiality, elevates the patient's individual interests over society's interests in protecting intended victims."[560] It is not sound to allow patients to transmit threats via psychotherapists' *Tarasoff* duties. It would be odd to allow "a criminal [to] perpetrate his crimes (the threats)" via a psychotherapist "with no opportunity for the listener to avoid facilitating the crime."[561] And Judge Boggs's dissent is persuasive in *Hayes*, because "[t]ender concern for criminal evidence is [not] required by the common law, or by reason and experience, when the patient has been put on notice."[562]

B. *Ways To Minimize Harm to the Psychotherapist-Patient Treatment Relationship*

When the Supreme Court of California issued the *Tarasoff* decision, the *Tarasoff* duty was met with great trepidation, even outrage, within the profession of psychotherapy.[563] Psychotherapists feared that patients would be dissuaded from confiding in psychotherapists if patients knew that certain communications would not be confidential.[564] Many decades later, the facial validity of the "deterrence hypothesis" is deflated because of several empirical studies showing most patients are actually accepting of a psychotherapist's *Tarasoff* duty to warn.[565] *Auster* places the deterrence hypothesis back in the spotlight. Now the concern is whether patients would be unlikely to share certain information with their psychotherapists

556. For example, in *United States v. Wimberly*, discussed in Part I.A.4.b, the court determined that a nonadult patient demonstrated his understanding of an advisory as to the limits of confidentiality by signing a waiver. *See supra* note 146 and accompanying text.

557. *See supra* text accompanying note 476, 479.

558. *See supra* text accompanying notes 541–44 and accompanying text.

559. McKeever, *supra* note 265, at 144.

560. *Id.*

561. United States v. Hayes, 227 F.3d 578, 589 (6th Cir. 2000) (Boggs, J., dissenting).

562. *Id.* at 588.

563. *See supra* notes 192, 235–38 and accompanying text.

564. *See supra* notes 235–39 and accompanying text.

565. *See supra* notes 240–53 and accompanying text.

when they are advised that certain communications will not be confidential and, thus, they will have no claim to privilege in those communications.[566]

Common law recognizes the psychotherapist-patient privilege in light of both "reason and experience."[567] The decision in *Auster* is sound as to why privilege does not exist as a matter of law.[568] Defending this position on the basis of practical experience is more difficult. Although empirical studies suggest that a patient's awareness of privilege does not seem to affect his candor during treatment,[569] many of these studies suffer weaknesses.[570] In fact, there are several studies that support the premise that patients would not divulge information freely to their psychotherapists if they were told that therapists could disclose their communications and even testify about them.[571] This is especially true when the patient recognizes that the testimony could harm him.[572] For instance, a patient may be willing to divulge thoughts of harm where the therapist was going to testify at a civil commitment hearing because he may recognize that forced mental health treatment is to his benefit; a patient may not be willing to divulge his threats where the therapist was going to testify at a criminal proceeding, where there are potential punitive consequences.[573] Admittedly, the deterrence hypothesis is at play in the case of *Scott v. Edinburg*, discussed in Part I.A.4.a.[574] There, the court determined that no privilege existed where the police officer was informed that his psychotherapy evaluation would be shared with his employer and could potentially be subpoenaed in litigation proceedings.[575] As a result, the officer refrained from making certain statements during the therapy and even explained that it was because he knew the interview would not be kept confidential.[576] Thus, the patient self-censored because he intended his communication to remain private, rather than risk being sued or losing his job. A criminal proceeding is an even more compelling scenario where the patient would want to be made aware of the status of his claim of privilege.

Auster and the other opinions discussed in Part II.C of this Note soundly reason that the validity of a claim of privilege turns on the patient's expectation of limited confidentiality at the time he utters a threat, rather than the patient's awareness of the status of privilege. The Fifth Circuit's decision is significant because it calls for psychotherapists to adapt their practices accordingly.[577] The decision is still very new. It is too soon to

566. *See supra* note 274 and accompanying text.
567. *See supra* notes 63–64 and accompanying text.
568. *See supra* Part III.A.
569. *See supra* notes 266, 280–84 and accompanying text.
570. *See supra* notes 292–94 and accompanying text.
571. *See supra* notes 277–79 and accompanying text.
572. *See supra* notes 285–89 and accompanying text.
573. *See supra* notes 289–91 and accompanying text.
574. *See supra* notes 101–02 and accompanying text.
575. *See supra* notes 101–02 and accompanying text.
576. *See supra* notes 101–02 and accompanying text.
577. *See supra* note 295 and accompanying text.

determine how psychotherapists will treat the opinion. It is certainly plausible, however, that some psychotherapists might refrain from advising patients of the *Tarasoff* duty to protect patients' claims of privilege later on.

This Note began with some advice to patients about the limits of confidentiality during their mental health therapy. It now turns to some advice to psychotherapists about how to live with the *Auster* precedent and ways to protect the psychotherapist-patient treatment relationship.

First, psychotherapists should resist treating a *Tarasoff* duty as legally required unless it is, in fact, mandated by law.[578] Not all state *Tarasoff*-model laws are. In the last few decades, the role of psychotherapists has broadened into that of a guardian of society.[579] It is a heavy burden, but practicing psychotherapists need to know the scope of their states' applicable *Tarasoff*-model law; it is insufficient to rely on general knowledge about the duty, given the varied statutory language and inconsistent application by courts.[580]

Professional associations should urge their members to participate in training and practice of ethicolegal decision making, which incorporates a therapeutic approach to treating dangerous patients and is more consistent with the patient's interest in improving mental health.[581] This means that a psychotherapist should explore alternative intervention techniques to mitigate the seriousness of his patient's threat or reduce the risk that the patient will act upon it.[582] A *Tarasoff* warning can be used as a "last resort."[583]

After *Auster*, some psychotherapists may wonder if they should continue advising patients of the *Tarasoff* duty. Although advisories educate the patient about the limits of confidentiality, the *Auster* decision signifies that advisories about *Tarasoff* can also destroy the patient's chance to later claim privilege.[584]

Advisories are necessary to strengthen a therapeutic alliance because informed consent grounds the patient's trust.[585] A patient is entitled to know how much of his conversation is private, especially if it could incriminate him later on.[586] Another reason that psychotherapists should continue to advise patients of a *Tarasoff* duty is because a thorough advisory under the informed consent doctrine could memorialize the patient's wishes to remain confidential, at some level, even if in actuality the patient does not have a real choice about *Tarasoff* disclosures.[587] As in most of the cases discussed in Part I.A.4 that involved police officers

578. *See supra* notes 187–90 and accompanying text.
579. *See supra* text accompanying note 197.
580. *See supra* notes 179–85, 188, 190 and accompanying text.
581. *See supra* notes 193, 194, 205–06, 261–62 and accompanying text.
582. *See supra* notes 193, 194, 205–06, 261–62 and accompanying text.
583. *See supra* note 196 and accompanying text.
584. *See supra* Part III.A.
585. *See supra* notes 205–06, 261–62 and accompanying text.
586. *See supra* notes 201–04 and accompanying text.
587. *See supra* notes 297–300 and accompanying text.

subject to employer-mandated therapy sessions, the confidentiality requirement of privilege requires that the privilege holder intended his communication to remain confidential.[588] When the Fifth Circuit decided *Auster*, it had no such evidence; to the contrary, evidence made it clear that Auster had every intention for his psychotherapist to forward his threat to the intended victim as part of his "violent retribution" and intimidation.[589]

CONCLUSION

A patient's threat that is communicated to a psychotherapist after an advisory about the psychotherapist's *Tarasoff* duty to warn cannot be considered privileged where the patient's subsequent threat after the advisory confirms the patient's intention not to keep it confidential. Furthermore, the lack of privilege for these statements will not harm the therapy relationship, providing psychotherapists observe the following practices: take note of whether their states' *Tarasoff*-model law is mandatory, take a therapeutic approach by considering alternative intervention techniques to minimize the risk of harm to the patient and others before a *Tarasoff* warning becomes necessary, and adhere to an informed consent model that builds a therapeutic alliance and protects a patient's claim for privilege in the future if the patient truly wishes the threat be kept privately.[590]

Privilege is not designed to be overprotective and inclusive of nonconfidential communications that the patient never intended to be kept privately.[591] Enforcement of the confidentiality requirement of privilege ensures that testimony is not suppressed regarding communication that would have occurred even if there was no privilege.[592] Auster was trying to use privilege as both a "shield and a sword,"[593] by disclosing his "privileged" communication and then shielding the communication from testimony at trial. This dilemma can only be resolved if courts find that privilege never attached or that there was never an effective waiver of privilege. In cases like *Auster*, where the defendant fully intended the psychotherapist to deliver his threat, there should be no shielding of this information at a trial proceeding. There should be no "[t]ender concern for criminal evidence . . . required by . . . common law, or by reason and experience, when the patient has been put on notice."[594]

588. *See supra* notes 30, 40, 94 and accompanying text.
589. *See supra* notes 478–79 and accompanying text.
590. *See supra* Part III.B.
591. *See supra* text accompanying notes 29, 32–33.
592. *See supra* text accompanying notes 29, 32–33.
593. *See In re* Sims, 534 F.3d 117, 138 (2d Cir. 2008) (citing *In re* Grand Jury Proceedings, 219 F.3d 175, 182 (2d Cir. 2000)).
594. United States v. Hayes, 227 F.3d 578, 588 (6th Cir. 2000) (Boggs, J., dissenting).